

**Western NC Community Health Services, Inc.  
Medical Enrollment Form**

**INSTRUCTIONS: Read carefully.** Provide **ALL** the information requested. Print clearly in ink. After completing it, return the Enrollment Form by doing any one of the following:

- Handing it to any Minnie Jones Health Center front desk or security staff member.
- Placing it in the box labeled “Enrollment Forms Only”, located outside the main entrance (west side) of the **Minnie Jones Health Center, 257 Biltmore Ave., Asheville, NC.** (This is available 24/7.)
- Sending through U.S. mail to: **Minnie Jones Health Center, PO Box 338, Asheville, NC, 28802.**

If the Enrollment Form is complete when we receive it, we will call you to schedule your appointment.

**Applicant’s First Name:** \_\_\_\_\_

**Applicant’s Last Name:** \_\_\_\_\_

**Applicant’s Date of Birth:** \_\_\_\_\_

**Applicants’ Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_

**Applicant’s Phone Number** (\_\_\_\_\_) \_\_\_\_\_

**Applicant’s e-mail address:** \_\_\_\_\_

**For Patient Appointment reminder please check the preferred method below**

- Mail**    **Phone**    **Text**    **Email**

1) Applicant’s preferred language is: English\_\_ Other\_\_ (specify): \_\_\_\_\_

2) Are you seeking trans affirming care? Y\_\_\_\_\_ N\_\_\_\_\_

3) Are you seeking Ryan White / HIV care? Y\_\_\_\_\_ N\_\_\_\_\_

Is there anything else you would like us to know? **(Optional)** \_\_\_\_\_

**Signature of applicant or guardian/legal representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_