Building a Healthy Community

Empower "U", Inc.

Community Health Center

"Serving people regardless of the ability to pay"

PATIENT INTAKE FORM

Initial Date: _____ Today's Date: _____ Patient ID #: _____

Mother's Maiden Name? Last Name: _____ First Name: _____

Patient Name: _____ S.S. #: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female ☐ Transgender (☐ M to F or ☐ F to M)

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered

Race: ☐ White ☐ African American ☐ American Indian or Native American
☐ Asian Pacific Islander ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

What is your preferred language: ☐ English ☐ Español ☐ Kreyol ☐ Other: _____

PATIENT CONTACT INFORMATION

Address: _____

_____ _____ _____
City State Zip Code

Home Telephone Number: _____ Alternate Contact: _____

Cell Phone Number: _____

Is it ok to contact you? ☐ Yes ☐ No

EMAIL ADDRESS: _____ @ _____

TEXT Contact Number: _____

Best Contact for Appointment? ☐ Mail ☐ E-mail ☐ Cell phone call ☐ Cell phone text

☐ Yes ☐ No Is it OK to contact me for alerts, administrative updates, health information and health promotions, health fair invites, and other social events and announcements.

INCOME INFORMATION

Employment: ☐ Yes ☐ No If yes, how long? _____ Disabled? ☐ Yes ☐ No If yes, how long? _____

Employer: _____

Address: _____

_____ _____ _____
City State Zip Code

Employer Contact Number: _____ Annual Income: _____
(Check Stub, W2, Disability, etc.)

Student: ☐ Yes ☐ No If yes, what grade level? _____ Household Size: _____

School Name: _____ Is your vaccine record current? ☐ Yes ☐ No ☐ Unknown

If you are a minor this Form Must Be Completed by Parent/Legal Guardian

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EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____

_____ _____ _____

City State Zip Code

Telephone Number: _____ Other Phone: _____

How did you hear about our practice? ☐ Family ☐ Friend ☐ Patient ☐ Radio ☐ Flyer/Card

☐ Other: _____

INSURANCE INFORMATION

Primary Insurance

Plan Name: _____

I.D. Number: _____

Group Number: _____

Effective Date: _____

Policy Holder Name: _____

Date of Birth: _____/_____/_____ S.S. #: _____

Secondary Insurance

Plan Name: _____

I.D. Number: _____

Group Number: _____

Effective Date: _____

Policy Holder Name: _____

Date of Birth: _____/_____/_____ S.S. #: _____

It is the policy of the health center to serve all patients regardless of the inability to pay.

Individuals and families who have income less than 200% of the Federal Poverty Level may apply for the Sliding Fee Discount Program (SFDP). Individuals and Families who are eligible will pay for service rendered based on the Sliding Fee Discount Schedule (SFDS). You must complete the application and have all required documents at the time of service to be eligible for the program or you will be charged/or service based on the health center's fee schedule. Patient who require emergency service will be assessed by the Medical Director or his/her designee.

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PAYMENT RESPONSIBLE PARTY

Guarantor Last Name: _____ First Name: _____

S.S. #: _____ Date of Birth: _____/_____/_____

Relationship to Patient? ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian

Address: _____

_____ _____ _____

City State Zip Code

Telephone Number: _____ Other Phone: _____

Is your visit due to job related injury or automobile accident? ☐ Yes ☐ No

OFFICE POLICIES

My signature below indicates that I have been provided with a Client Notice Handbook and/or document with the following information: HIPPA, Notice of Privacy Practices, The Rights and Responsibilities, Grievance Policy & Procedures, and Sliding Scale Fee Discount Application, Hours and After or Operation, Living Will, and Health Surrogate.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Witness Signature Date

***** OFFICE USE ONLY *****

The checked document(s) were refused by the patient or parent/legal guardian:

☐ Client Handbook Notices

☐ Living Will and Advanced Directives

☐ Sliding Scale Fee Discount Application

_____ _____

Employee Signature Date

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INFORMED CONSENT FOR RECEIVING TREATMENT

I, _____, _____☐ (Patient) or ☐ (Parent or Guardian of minor child) do hereby voluntarily consent to the rendering of medical care, including diagnostic procedures and medical treatment, by authorized members of the Empower "U", Inc. Community Health Center (EUCHC) clinical staff or their designees, as may be in their professional judgment necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on me.

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to EUCHC. I acknowledge that I am financially responsible for the payment whether or not covered by insurance.

I have read this form and certify by signing below that I understand its contents and have been given explanation of the benefit and risks of treatment.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Witness Signature Date

CONSENT FOR TO SHARE PHI WITH DESIGNATED INDIVIDUALS

I give consent to Empower "U", Inc. CHC the authority to discuss my health information with the following individuals:

Name	Relationship	Phone Number	May we leave a voice mail
1.	Parent/Legal Guardian		
2.			
3.			

_____ _____

Patient or Parent/Legal Guardian Signature Witness Signature

(If, the patient being treated is under 18 years of age Parent or Legal Guardian's Consent is required for treatment)

If you are a minor this Form Must Be Completed by Parent/Legal Guardian

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2017 SLIDING FEE DISCOUNT APPLICATION

(This application may be completed by EUCHC health center patient regardless of source of primary payment e.g. insurance or self-pay.) (This application may be used for multiple members of household)

SECTION I APPLICANT INFORMATION

Name: _____ _____ _____ Date: _____
First M. I. Last

S.S. #: _____ Date of Birth: _____/_____/_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Spouse Name: _____

Applicant relationship to patient(s)? ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian

List patients who need assistance with medical care cost? 1.) _____ 2.) _____

SECTION II AFFIDAVIT TO WAIVER THE SLIDING FEE DISCOUNT PROGRAM

I have been informed of my option to apply for a discounted fee on my service based on my household income and family size. At this time I choose freely without coercion NOT TO APPLY for a discount fee or nominal fee.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date

SECTION III HOUSEHOLD SIZE AND INCOME INFORMATION

Please list everyone living in your home (including yourself) and any one whom you claim as a dependent on your federal income tax return. Non-related adults should be listed if they contribute to the household income (food/rent/utilities). If dependent over 18 years of age, indicate if they are a student. In order to be considered a household member, the person must be listed below. Adults (except for spouse) listed below with zero income must provide documentation.

Name (First and Last)	Age	Insurance (Yes or No)	Relationship to Applicant	Source of Income (Wages, Social Security, Unemployment, Food Stamps, etc.)	How often are you paid? (Weekly Bi-Weekly Monthly, etc.)
1.			Head of Household		
2.					
3.					
4.					
5.					
6.					
7.					
8					

Please include income documentation for each ADULT listed above.

_____ Total # of adults (18 years of age and older) _____ Total # of children (under 18 years of age)
_____ Total # of household members $ _____ Total estimated gross annual income

Eligibility Verification: Proof of income, household size, and insurance information (copies must be on file to assess sliding scale and/or hierarchy or payers of last resort, e.g. private insurance, Medicaid/Medicare, federal programs like Ryan White, CHC Sliding Fee Scale).

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******* OFFICE USE ONLY *******

Income Verification:

- ☐ Copy Pay Check Stub
- ☐ Food Stamp Award Letter
- ☐ Bank Statement
- ☐ TPQY (All household members)
- ☐ SSI/SSD Award Letter
- ☐ Income Tax Return
- ☐ Unemployment Benefit Statement
- ☐ Letter of Support (Notarized)
- ☐ Other Income Proof: _____

SECTION IV INSURANCE

Do you or the patient have medical/dental insurance? ☐ Yes ☐ No

If YES, please provide a copy of the front and back of your insurance card(s) to the front desk.

☐ Copy of insurance Card	☐ Verification Date: _____	Staff Name:	_____
☐ Medicaid/Medicare	☐ Verification Date: _____	Staff Name:	_____
☐ Private Insurance	☐ Verification Date: _____	Staff Name:	_____

Plan Name: _____

SECTION V ZERO INCOME DOCUMENTATION

Adults (age 18 and over) living in your home whom you are claiming as a member of your household on this application must provide documentation of their zero income status.

Notarized Letter: A letter from a person or facility where you are currently staying stating that they are providing for basic needs (food/shelter/clothing) and that you do not currently have a source of income. The letter must be **NOTARIZED**, dated within the past 30 days; singed; and include the contact information (address and telephone number) of the person who wrote the letter. By providing this information, you are giving us permission to contact this person for verification of the zero income status.

Income Verification from Family Services: If you are receiving food stamps or temporary assistance from needy families (TANF), a copy of the income verification or statement from the Family Services Office will be sufficient. TPQY: Third Party Query for Social Security income verification demonstrating zero income.

You must provide one of the options listed above for Zero Income Demonstration.

SECTION VI APPLICANT AFFIDAVIT

I certify that the information on this application is true and accurate. I understand that it is my responsibility to complete the application and provide the required proof of income documentation in order to apply for discounted services. I understand that if I do not provide the required income documentation on my initial visit, I will be responsible for the full charges. I understand that to qualify for the Sliding Fee discount I must provide the required income and household size documentation. I agree to inform EUCHC if my financial situation changes significantly. I also understand that falsifying information or documentation on this application will result in my application being denied and any applicable discounts received under raise pretenses will be revoked and I will be responsible for all the charges. I understand that this application and any discount that I may qualify for will apply only to the patient listed on this application. Any/all additional patients would need to apply separately.

_____	_____	_____
Applicant (Print)	Applicant (Signature)	Date
_____	_____	_____
Staff (Print)	Staff (Signature)	Date

THIS FORM MUST BE COMPLETED EVERY 6 MONTHS OR IF YOUR FINANCIAL SITUATION CHANGES.

If you are a minor this Form Must Be Completed by Parent/Legal Guardian