Patient Registration Paperwork

Great Mines
HEALTH CENTER

We look forward to assisting you!!

Main Location:	Farmington Location:	School-Based Services
#1 Southtowne Dr	508 West Pine St	Call (573) GET-WELL
Potosi, MO 63664	Farmington, MO 63640	438-9355
(573) 438- 9355	(573) 664-1100	

Patient Registration Paperwork

Sliding Fee Discount

Sliding Scale Discount Program fees for clinic services are based on your income and family size and may be reduced if you live on a limited income according to federal guidelines. To qualify for discounts, you must present the following information as applicable:

Acceptable documentation for proof of income (please provide proof for all Family/household income):

- Current Paycheck stub.
- A letter on company letterhead. Please include the following information: hourly rate, gross pay and the pay period. If your employer does not have company letterhead, we will accept a notarized letter from your Employer. Please include the following information: hourly rate, gross pay and the pay period.
- Current Unemployment Determination Letter.
- Social Security, pension, trust, SSI Disability award letter, food stamp summary or child support check.
- Current financial aid, Pell Grants, scholarships papers.
- Current tax information.
- W2 Forms (gross income).
- For elderly parents living with adult children or adult grandchildren, include income if adult children or adult grandchildren claim parents as dependents on their tax return. Otherwise, parents should be considered as independent for the purposes of Income. (Do not count their adult children's income).
- Noncash items such as food stamps are *not* included in the income

Acceptable documentation for proof of family size (please provide proof for all Family/household income):

- Current Tax Return or tax information
- Driver's License (must include current address)
- Social Security, pension, trust, SSI Disability award letter, food stamp summary or child support check or child support summary, birth certificate or any government issued letter.
- Current piece of mail with Family/Household members name included
- Letter from Department of Family Services or Court Order

Who does GMHC define as "Family/Household"

- Husband, Wife and dependent Children (any age, related biologically or adopted)
- Significant Other
- Unmarried Partners
- Mother Father if included on the tax return
- Grand Parents if included on the tax return
- Grand Children if included on the tax return
- All members included on the tax return

- **PLEASE ENSURE YOU RETURN ALL THE INFORMATION AT THE SAME TIME**

I understand if I do not provide the above information within thirty (30) days from today, I will be fully responsible for all services rendered and these services will be billed at the full price until information is returned, however, I will be awarded the discount on the initial visit based upon Federal Poverty Level guidelines of my self-declared income/family size on the Sliding Fee Discount Application.

You will need to Present a copy of the following at the time of each visit:

- Driver's License or Photo Id
- Insurance Cards, if applicable

Today's Date: _____ Great Mines Health Center Patient Registration Paperwork

Patient Information

First Name: Middle Name: Last Name:

Preferred Pharmacy: | Primary Care Provider:

Former Name: | Preferred Name:

Date of Birth (MM/DD/YYYY): | Social Security Number:

Physical Address:

_____

(Street Address) (City) (State) (Zip)

Mailing Address: ☐ Same as Address Listed Above

_____

(Street Address) (City) (State) (Zip)

Primary Phone Number: ( )
☐ Home ☐ Cell ☐ Work

Alternate Phone Number: ( )
☐ Home ☐ Cell ☐ Work

Email Address:

Employment Information: ☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐N/A

Occupation: Employer: Employer Phone: ( )

As an FQHC we are required to ask you the following questions:

Sex Assigned at Birth: ☐ Female ☐ Male

Gender Identity
☐Female ☐ Male ☐ Choose Not to Disclose
☐Transgender Male/Female to Male
☐Transgender Female/Male to Female
☐ Other: _____

Sexual Orientation
☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual
☐ Bisexual ☐ Other: _____
☐ Don't Know ☐ Choose Not to Disclose

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

What is your race? (Check all that apply)
☐ More Than One Race ☐ Korean
☐ American Indian/ Alaska Native ☐ Vietnamese
☐ Asian Indian ☐ White
☐ Black/African American ☐ Unknown
☐ Chinese ☐ Other: _____
☐ Japanese ☐ Choose Not to Disclose

What is your ethnicity?
☐ Chicano ☐ Not Hispanic, Latino/a or Spanish Origin
☐ Cuban ☐ Other Hispanic, Latino/a or Spanish Origin
☐ Mexican ☐ Puerto Rican
☐ Mexican American
☐ Choose Not to Disclose
☐ Other: _____

Primary/Preferred Language:
☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese
☐Other_____

Do you need an Interpreter? ☐Yes ☐ No

Are you a migrant /seasonal worker?
☐ Migrant ☐ Seasonal ☐ Neither

Are you experiencing homelessness?
☐ Yes ☐ No (Not Homeless)
If "Yes", please choose one (1) below:
☐ Living in Shelter (Homeless Shelter) ☐ Transitional Housing
☐ Living with Others (Doubling Up) ☐ Street, Camp, Bridge
☐ Permanent Supportive Housing ☐ Other

Are you a Veteran? ☐ Yes ☐ No

Do you have an advance directive? ☐ Yes ☐ No **If yes, is it on file with us?** ☐ Yes ☐ No

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge.

_____ _____
Print Name of Patient **Relationship to patient of Individual Signing Form**

_____ _____
Parent/Guardian Signature **Date**

Parent/Responsible Party: Required for patients less than 18 and whenever the guarantor is not the patient

Name (First, M.I., Last): ____Date of Birth: _________________

Relationship to Patient: ________________ Phone: _______________Email: _______________________________

Address: ☐ Same as Patient

____

(Street Address) (City) (State) (Zip)

Occupation: Employer: Employer Phone: ( )

Insurance Information

☐Medical ☐Dental

Primary Insurance Company:		Policy #	Group #	Copay:
Policy Holder Name:	Policy Holder DOB:	Relation:	Social Security #:	Employer:
Secondary Insurance Company:		Policy #	Group #	Copay:
Policy Holder Name:	Policy Holder DOB:	Relation:	Social Security #:	Employer:
Tertiary Insurance Company:		Policy #	Group #	Copay:
Policy Holder Name:	Policy Holder DOB:	Relation:	Social Security #:	Employer:

Contacts

Must have one person listed as Emergency Contact

Health information that Great Mines Health Center collects or receives about me may be disclosed to the following persons:

Name:	**Relationship:**			**Phone Number:**
Address:				
Check all that apply:	☐ Emergency Contact	☐ May Share Information	☐May Leave Voice Message	☐ May Make Appointments
☐ May Bring Minor to Appointments	☐ Authorized to Make Medical Decisions, Including Procedures and Vaccinations (Notary Form Required)			☐ Power of Attorney
Name:	**Relationship:**			**Phone Number:**
Address:				
Check all that apply:	☐ Emergency Contact	☐ May Share Information	☐May Leave Voice Message	☐ May Make Appointments
☐ May Bring Minor to Appointments	☐ Authorized to Make Medical Decisions, Including Procedures and Vaccinations (Notary Form Required)			☐ Power of Attorney
Name:	**Relationship:**			**Phone Number:**
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☐ May Bring Minor to Appointments	☐ Authorized to Make Medical Decisions, Including Procedures and Vaccinations (Notary Form Required)			☐ Power of Attorney

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge.

_______________________________ _______________________________

Print Name of Patient **Relationship to patient of Individual Signing Form**

_______________________________ _______________________________

Parent/Guardian Signature **Date**

Today's Date: _____ Patient Name: _____ Patient Date of Birth: _____

PRAPARE Assessment Questions

At Great Mines Health Center, we want to make sure that we provide the best care and services possible to meet your needs. This information will help us determine if we need to add new services or programs to meet the needs of our patients. **This information will be kept private and secure.** Your decision to answer or to refuse to answer will NOT impact your ability to receive care. In many cases, this information will help us determine if you are eligible for any additional benefits, programs, or services. Please let us know if you have any questions, concerns, or suggestions.

Have you been discharged from the armed forces of the United States?
☐ Yes ☐ No ☐ Choose Not to Disclose

How many family members, including yourself, currently live in your home?
#_____ ☐ Choose Not to Disclose

Are you worried about losing your housing?
☐ Yes ☐ No ☐ Choose Not to Disclose

What is the highest level of school that you have finished?
☐ Less than high school degree ☐ High school diploma or GED ☐ More than high school ☐ Choose Not to Disclose

What is your current work situation?
☐ Unemployed ☐ Part-time or temporary work ☐ Full-time work
☐Not seeking work (student, retired, disabled, care giver, homemaker) ☐ Choose Not to Disclose

During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.
$_____ ☐ Choose Not to Disclose

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.
☐ Food ☐ Clothing ☐ Child Care ☐ Utilities ☐ Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)
☐ Phone ☐ Other _____ ☐ Choose Not to Disclose

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.
☐ Yes, it has kept me from medical appointments or from getting my medications.
☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things I need
☐ No ☐ Choose Not to Disclose

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
☐ Less than once a week ☐ 1-2 times a week ☐ 3-5 times a week ☐ 6 or more times a week ☐ Choose Not to Disclose

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?
☐Not at all ☐A little bit ☐Somewhat ☐Quite a bit ☐Very much ☐Choose Not to Disclose

In the past year, have you spent more than two nights in a row in a jail, prison, detention center, or juvenile correctional facility?
☐ Yes ☐ No ☐ Choose Not to Disclose

Are you a refugee?
☐ Yes ☐ No ☐ Choose Not to Disclose

Do you feel physically and emotionally safe where you currently live?
☐ Yes ☐ No ☐ Choose Not to Disclose

In the past year, have you been afraid of your partner or ex-partner?
☐ Yes ☐ No ☐ I have not had a partner in the past year ☐ Choose Not to Disclose

Sliding Scale Discount Program Application

It is the policy of Great Mines Health Center to provide primary care services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside entities, including but not limited to: reference laboratory testing, drugs, medical devices, and other such services. This form must be completed every 12 months or if your financial situation and/or family size changes.
Please initial what applies to you:

1. _____ I am a new patient with GMHC, I do not have insurance and I did not bring my proof of income. This form serves as a Self-Statement of income for my first New-Patient visit only. *I am aware I have 30 days to return proof of income*
2. _____ I am an established patient at GMHC and recently lost my insurance coverage. This form serves as a Self-Statement of income for today's visit only. *I am aware I have 30 days to return proof of income*
3. _____ I have insurance but would like to submit this application for any services not covered by my insurance company and/or for services that I choose to not submit to my insurance company. *I am aware I have 30 days to return proof of income*

Head of Household: Yes or No Name of Head of Household _____
Address:_____
Street City, State, Zip

Place of Employment:_____

RELATIONSHIP	**NAME**	**DATE OF BIRTH**	**PHONE**	**Currently a GMHC Patient Y/N**
SELF				
SPOUSE				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				

Sliding Fee Discount Application

Annual Household Income – Based on ***Annual*** compensation

SOURCE	SELF	SPOUSE	DEPENDENT/OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income from business/self-employment				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
TOTAL INCOME				

I, the person who has signed below, have filled out this application for the Sliding Fee Discount consideration and can prove that this information is true and correct, to the best of my knowledge. I am also aware that if there is any change in financial status of any of the people in my household it must be report immediately to Great Mines Health Center, (GMHC) and a new application must be filled out. I understand that, upon request of GMHC, and yearly, there will be a review of my application with the chance of discount amount changes. I understand that any untrue information written on form or the failure to provide proof of income and proof of family size, within 30 days, may result in the disapproval for the Discount Fee reduced priced made available by GMHC. I also understand this discount service is for services provided within GMHC only.

Applicants Signature:_____**Date:**_____

As a Federally Qualified Health Care Center we are required to collect certain information. The information on this form is used to determine the amount of discount that you may receive from GMHC and/or for statistical purposes. I understand that my personal or financial information will not be released.

BELOW TO BE COMPLETED BY GMHC STAFF ONLY

Patient Name:_____ 30 day Expiration date for POI/PFS:_____

Initial Visit: Approved Discount:_____ or Denied Due to:_____

GMHC Staff:_____ Date:_____ Notes:_____

Verification Checklist	Yes	No
Proof of Income (POI): Current Year Tax Return, Recent Pay Stubs or Other:_____		
Proof of Family Size (PFS): Current Tax return, Government issued letter, mail (includes each family member with same address)		