Your Community Health Center
If you need help filling out this form, please let us know.

PATIENT REGISTRATION FORM

(Please Print)

Today's Date:	YCHC Medical Provider:	YCHC Dental Provider:

PATIENT INFORMATION

Patient First Name	MI	Last Name	Date of Birth / /	Age

Street Address	City	State	Zip

Mailing Address: ☐ Same as Above	SSN - -

Email Address	Home Phone Number ( ) -	Cell Phone Number ( ) -	Work Phone Number ( ) -
Preferred Pharmacy	Pharmacy Location		Phone number for reminder calls
☐Parent ☐ Guardian ☐ Spouse Name:	Date of Birth	Address: ☐ Same as Above	Phone Number ( ) -

MEDICAL INSURANCE INFORMATION

Person Responsible for Bill	Birth Date / /	Address (if different)	Phone Number ( ) -
Occupation:	Employer:		Employer Phone:

Relationship to Subscriber ☐Self ☐ Child ☐ Spouse ☐ Step Child ☐ Other_____________

Primary Insurance
☐Medicare ☐ Medicaid ☐ Blue Cross ☐ Cigna ☐ Other_______________

Subscriber Name	Policy #	Group #	Subscriber DOB	Subscriber SSN	Co-Pay $

Secondary Insurance
☐Medicare ☐ Medicaid ☐ Blue Cross ☐ Cigna ☐ Other_______________

Subscriber Name	Policy #	Group #	Subscriber DOB	Subscriber SSN	Co-Pay $

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Subscriber Name	Policy #	Group #	Subscriber DOB	Subscriber SSN

IN CASE OF EMERGENCY

Name of Friend or Relative	Relationship to Patient	Primary Number ( )	Secondary Number ( )

ADVANCE HEALTH DIRECTIVE

☐ I have a Living Will	☐ I have durable power of attorney for health	☐ I do not have living will or durable power of attorney	☐ I want more information about a living will

PRIOR MEDICAL RECORDS

☐ Please request my prior records	Provider	Address	Telephone Number

The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Your Community Health Center. I understand that I am financially responsible for any balance. I also authorize Your Community Health Center or my insurance company to release any information required to process my claims.

Signature:____Date: __________________________

Circle of Care: Names of Other Providers Who are Treating You including dentists, specialists, behavioral health		
Name:	**Specialty:**	**Phone:**
1.		
2.		
3.		

Ethnicity

☐	Hispanic or Latino
☐	Not Hispanic
☐	Unreported /Refused to Report Ethnicity

Race

☐	Asian
☐	Native Hawaiian
☐	Other Pacific Islander
☐	Black/African American
☐	American Indian/ Alaska Native
☐	White (not Hispanic or Latino)
☐	More than one race
☐	Not Reported / Refuse to Report

Primary Language

☐	English
☐	Spanish
☐	Russian
☐	Ukrainian
☐	Other Please Specify:

How did you hear about us?

☐	Newspaper/TV/Radio Ad
☐	Website
☐	Special Event
☐	Employee
☐	Other Organization
☐	Friend
☐	Other

Do you identify yourself as:

☐	Straight or heterosexual
☐	Lesbian, gay or homosexual
☐	Bisexual
☐	Something else
☐	Don't know
☐	Chose not to disclose
☐	Other

Education

☐	Current Student?
☐	Full Time
☐	Part Time

Highest Level of Education

☐	Not yet in school
☐	Pre-School Kindergarten
☐	Grade School
☐	Middle School
☐	High School
☐	High School Degree/ GED
☐	Did not complete High School
☐	Technical Trade School
☐	College
☐	College Graduate

YCHC is my primary medical home?

☐	Yes
☐	No

What is your current gender identity?

☐	Female
☐	Male
☐	Transgender Male Female-to-Male
☐	Transgender Female Male-to-Female
☐	Gender queer, neither exclusively male nor female
☐	Other
☐	Chose not to disclose

Employment Status

☐	Full Time/ Part Time
☐	Migrant Worker
☐	Not a Migrant Worker
☐	Seasonal

Housing

☐Homeless

☐Doubling Up ☐Shelter
☐Other ☐Street
☐Transitional ☐Unknown

☐Public Housing-HUD

Are you a veteran?

☐	Yes
☐	No

I am using YCHC today for an urgent care need?

☐	Yes
☐	No

What sex were you assigned at birth on your original birth certificate?

☐	Female
☐	Male
☐	Chose not to disclose

All requested information is for statistical purposes only and is necessary for receipt of federal grants to provide services.

PERSON(S) WHO MAY ACCOMPANY MINOR & MAKE DECISIONS FOR MEDICAL/DENTAL/ BEHAVIORAL TREATMENT		
Name:	**Relationship:**	**Phone:**
1.		
2.		
3.		

PERSON(S) WHO MAY OBTAIN MY HEALTH INFORMATION FROM YCHC		
Name:	**Relationship:**	**Phone:**
1.		
2.		

	Initial Here
CONSENT FOR TREATMENT: I, the undersigned, do consent for treatment as deemed necessary by the attending health care provider. I, the undersigned, do also consent to treatment by YCHC dental providers	
ALL CHARGES ARE DUE AT THE TIME THAT SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO THE VISIT. I authorize ***Your Community Health Center*** to release any medical information necessary to process claims and further authorize payment of medical benefits payable directly to ***Your Community Health Center.*** I understand that ***Your Community Health Center*** will file and complete the necessary steps to collect my insurance payment. However, if my insurance doesn't respond or payment is not made within 90 days, I understand that it is my responsibility to pay for any services rendered by ***Your Community Health Center.*** I further understand that ***Your Community Health Center*** may not be contracted with my insurance plan and I agree that I am responsible for charges denied for such reasons.	
Receipt of Our Missed Appointment Policy. I, the undersigned, do acknowledge receipt of the Visit Policy and will make every effort not to miss scheduled appointments and will notify YCHC with 24 hours' notice when I need to cancel an appointment.	
CONSENT FOR TREATMENT OF A MINOR. By signing this consent I represent that I have the legal responsibility for and authority to direct the medical treatment of the above patient, either as parent or legal guardian and I will hold harmless any attending physician or other person or entity against any claim that medical treatment provided to the above patient was not authorized. This consent includes this and subsequent office visits for which I bring this minor to this office. My permission also extends to releasing this medical record to consulting physicians if ever required to adequately diagnose and treat this minor.	
I consent for contact by telephone or text message or email for Appointment Reminders.	
Privacy Notice. I have been offered a copy of my rights to privacy of my protected health information.	
Patient Rights and Responsibilities. I have received a copy of YCHC's Patient Rights and responsibilities.	
Patient Portal Information Sheet. I have received a copy of YCHC's Patient Portal Letter.	
By signing below and initialing on the above lines, I have read and understand the above. **Signature: ____Date: _____**	
By signing below I acknowledge that I am an employee of Your Community Health Center and I have witnessed and can verify that the above signatures/initials are of the patient/patient representative. **Witness Signature:________________________Date:_____**	

Family Size and Income

(This is important information for our federal funding)

Patient Name: ____

Instructions: Please select the **family size** in the far left column. Then **please circle** Your **income range** to the right of your selected family size (in the same row.)

# Persons in Household	Household Income	100%		101%-125%		126%-150%		151%-200%		Over 200%	
Visit Fee		$20.00		$30.00		$40.00		$50.00		Full Pay	
1	Annual	0 -	12,140	12,141	15,155	15,156	18,170	18,171	24,200	24,201	+
	per month	0 -	1,085	1,086	1,336	1,337	1,627	1,628	2,178	2,179	+
	per week	0 -	311	312	369	370	436	437	563	564	
2	Annual	0 -	16,460	16,461	20,575	20,576	24,690	24,691	32,920	32,921	+
	per month	0 -	1,372	1,373	1,714	1,715	2,058	2,059	2,743	2,744	+
	per week	0 -	316	317	395	378	474	454	631	605	+
3	Annual	0 -	20,780	20,781	25,975	25,976	31,170	31,171	41,560	41,561	+
	per month	0 -	1,732	1,733	2,165	2,165	2,598	2,475	3,463	3,464	+
	per week	0 -	399	400	498	475	598	570	797	798	+
4	Annual	0 -	25,100	25,101	31,375	31,376	37,650	37,651	50,200	50,201	+
	per month	0 -	2,092	2,093	2,615	2,615	3,138	2,982	4,183	4,184	+
	per week	0 -	481	482	602	573	722	687	963	964	+
5	Annual	0 -	29,420	29,421	36,775	36,776	44,130	44,131	58,840	58,841	+
	per month	0 -	2,452	2,453	3,065	3,065	3,678	3,490	4,903	4,904	+
	per week	0 -	564	565	705	670	846	804	1,073	1,129	+
6	Annual	0 -	33,740	33,741	42,175	42,176	50,610	50,611	67,480	67,481	+
	per month	0 -	2,812	2,813	3,515	3,515	4,218	4,218	5,623	5,624	+
	per week	0 -	647	648	809	767	922	923	1,294	1,227	+
7	Annual	0 -	38,060	38,061	47,575	47,576	57,090	57,091	76,120	76,121	+
	per month	0 -	3,172	3,173	3,965	3,965	4,758	4,505	6,343	6,344	+
	per week	0 -	730	731	912	865	1,039	1,040	1,460	1,461	+
8	Annual	0 -	42,380	42,381	52,975	52,976	63,570	63,571	84,760	84,761	+
	per month	0 -	3,532	3,533	4,415	4,415	5,298	5,298	7,063	7,064	+
	per week	0 -	813	814	1,016	962	1,349	1,350	1,541	1,542	+

Sliding Fee Information

Thank you for selecting Your Community Health Center. Part of our mission for YCHC is to provide q u a l i t y services to you and your family. In doing so, YCHC offers a sliding fee adjustment for patients and members of their families (as defined below) who fall below 200% of the poverty guidelines as set forth by the Federal Government. Income levels are based on total "family" income, family is defined below. The amount of the discount and the income ranges for those discounts are set by YCHC's Board of Directors and approved by the Federal Government. Income guidelines are revised annually. Current discounts and income guidelines are available at Your Community Health Center.

The sliding fee application will cover all medically necessary medical, behavioral, and dental services. The costs of procedures, labs, tests, and provider visits that are deemed medically necessary will qualify for the sliding fee discount. The costs of procedures, labs, tests and provider visits that are deemed optional, cosmetic or experimental will be the responsibility of the patient requesting the services at 100% of the regular rate charged. Even if services are ordered by a provider, it does not necessarily mean that they are medically necessary.

Definitions

Family-A family means those persons within the same household (including dependents/partner) who are applying for the sliding fee discount using their combined income.

Individual-An individual is a person 18 years old or over who has verifiable income using the list below (*).

Income Verification

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify YCHC of that change. YCHC reserves the right to verify income with an employer at any time. (*) **Patients are required to provide at least two of the following items as verification of income.**

- Previous year tax return
- Previous year W-2 form(s)
- Current pay stubs (last 4 weeks, if possible)
- Lay-off notification from last employer
- Current information from unemployment office
- Denied Medicaid application and reason for denial)
- Pay Stubs from unemployment (last 4, if possible)

(Continued on next page)

If you were not required to file prior's years income tax return or you receive any of the following types of income, documentation must be submitted showing the amounts of each received by any member of the household.

- Child Support
- Food Stamps
- Welfare Assistance
- Social Security
- Unemployment
- Self-Employment Income
- Alimony
- Retirement Income
- Worker's Compensation
- Disability Income
- Any Other Income

Eligible Fees

Medical, Mental Health and Dental Services that are provided at YCHC are eligible for the sliding fee discounts. **Previous charges, OWI assessments, elective procedures and outside services are not eligible for a sliding fee discount. Deductibles are eligible for sliding fee discounts.**

Minimum Charge

There is a minimum medical, mental health and dental charge for all sliding fee visits, as approved by the YCHC Board of Directors. The minimum charge **must** be paid at the time of service regardless of insurance coverage.

Additional Information

Payment is required when services are rendered. Timeliness in completing this application is important. **Your application for the sliding fee discount will not be approved until complete documentation is received**. Until you are approved for a sliding fee discount, you will be responsible for the full charges associated with services you receive from YCHC unless any amounts are covered by other third party services. If you have any questions, staff at YCHC will assist you. Thank You!!

***Please note that all patients, regardless of sliding fee requests, are asked to complete income information on page 6, as it is necessary for continued clinic funding; patients who are wanting a sliding fee must fill out that information on pages 9-10, along with the income information.**

Thank you for your assistance.

Sliding Fee Application

Patient's Name:____

Home Address: ____

City: ____________________ State: _______ County:____________Zip: ____________

Sex: Female Male Date of Birth: __________

Home Phone: ______________ Work Phone: ______________

Employer/School:______________________________Occupation: ______________

Employer's Address: ____

Is your employment seasonal? Yes No

Is your employment related to agriculture? Yes/No

Number of people in your household? __________

Annual Gross Income (all adult members of household)? $____________________

Financially Responsible Party:

Name:____Date of Birth: _________

Relationship to Patient:________________________

Home Address: ____

City:________________State:_______Zip: ____________

Home Phone: ______________________ Cell Phone:_________________________

Family Size: (If additional space is needed, please add to back of page)

Name	Date of Birth	Relationship

Income:

	Current Monthly	Last 12 Months Total
Wages or Self Employment	$ ____________	$ ________________
Social Security/Public Assistance	$ _____________	$ __________________
Unemployment/Workers Comp	$ _____________	$ __________________
Alimony/Child Support	$ _____________	$ __________________
Pensions/Retirement Income	$ _____________	$__________________
Food Stamps/Welfare Assistance	$ _____________	$ _________________
Disability Income	$ _____________	$ __________________
Any Other Income	$ _____________	$ __________________

I declare under penalty of perjury, under laws of the State of Missouri, that all statements contained in this application and accompanying documents is true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial of application.

I have read the Sliding Fee Application and I understand that payment is due at the time of services. If documentation of income verification is not given to YCHC within 30 days of this application, the application will no longer be valid and you must reapply. Thank you in advance for your cooperation.

Signature: ____ Date: ______________________

For Office Use only:

Qualifies for:_______________________% Discount Ineligible

Date of Determination: _________________________

Signature of person making eligibility determination: ______________________________