



# ADULT PATIENT REGISTRATION FORM

Today's Date: \_\_\_\_\_

Form Type:  New Patient  Annual Update

## PATIENT INFORMATION

<b>Legal Last Name:</b>		<b>Legal First Name:</b>		<b>Legal Middle Name:</b>	<b>Preferred First Name:</b>
<b>Previous Full Name (if applicable):</b>		<b>Birth Date:</b> / /	<b>Age:</b>	<b>Social Security #:</b>	
<b>Sex at Birth:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Intersex <input type="checkbox"/> Not recorded on birth certificate					
<b>Cell Phone:</b>		<b>Home Phone:</b> <input type="checkbox"/> Same as Cell Phone		<b>Work Phone:</b> <input type="checkbox"/> Same as Cell Phone	
<b>Mailing Address:</b>			<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>E-Mail Address:</b>					

<b>Race:</b>					
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<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Asian	<b>Ethnicity:</b>		
<input type="checkbox"/> American Indian	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Mexican, Mexican American, or Chicano/a	<input type="checkbox"/> Another Hispanic, Latino/a, or Spanish Origin	
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Samoan	<input type="checkbox"/> White	<input type="checkbox"/> Multiple Hispanic, Latino/a, or Spanish Origin	<input type="checkbox"/> Non-Hispanic or Latino/a	
<input type="checkbox"/> Chinese	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Unknown	<input type="checkbox"/> Cuban	<input type="checkbox"/> Puerto Rican	
<input type="checkbox"/> Filipino	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Refuse to disclose	<input type="checkbox"/> Unknown	<input type="checkbox"/> Refuse to disclose	
<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Islander				

<b>Sexual Orientation:</b>		<b>Gender Identity:</b>		<b>Preferred Pronouns:</b>	
<input type="checkbox"/> Asexual	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Female	<input type="checkbox"/> Questioning	<input type="checkbox"/> she / her / hers	<input type="checkbox"/> ey / em / eirs
<input type="checkbox"/> Lesbian or Gay	<input type="checkbox"/> Omnisexual	<input type="checkbox"/> Male	<input type="checkbox"/> Two Spirit	<input type="checkbox"/> he / him / his	<input type="checkbox"/> ve / vir / vis
<input type="checkbox"/> Pansexual	<input type="checkbox"/> Queer	<input type="checkbox"/> Transgender Female	<input type="checkbox"/> Refuse to disclose	<input type="checkbox"/> they / them / theirs	<input type="checkbox"/> xe / xem / xyrs
<input type="checkbox"/> Straight (not lesbian or gay)	<input type="checkbox"/> Don't know	<input type="checkbox"/> Transgender Male	<input type="checkbox"/> Refuse to disclose	<input type="checkbox"/> patient's name	<input type="checkbox"/> Refuse to disclose
<input type="checkbox"/> Something Else	<input type="checkbox"/> Refuse to disclose	<input type="checkbox"/> Non-Binary / Genderqueer		<input type="checkbox"/> ze / hir / hirs	<input type="checkbox"/> Unknown
		<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____	

## EMPLOYMENT STATUS

<b>Employment Status:</b>			<b>Veteran/Military Status:</b>		
<input type="checkbox"/> Full time	<input type="checkbox"/> Self-employed	<input type="checkbox"/> Student Full-Time	<input type="checkbox"/> No previous experience	<input type="checkbox"/> Veteran	
<input type="checkbox"/> Part time	<input type="checkbox"/> Not employed	<input type="checkbox"/> Student Part-Time	<input type="checkbox"/> Active Duty	<input type="checkbox"/> Separated / Combat Veteran	
<input type="checkbox"/> Seasonal	<input type="checkbox"/> Unemployed	<input type="checkbox"/> On Active Military duty	<input type="checkbox"/> Inactive Duty		
<input type="checkbox"/> Retired	<input type="checkbox"/> due to disability		<input type="checkbox"/> Reservist		

Are you a current or former employee of our company and/or a family member of an employee?  Yes  No

## INSURANCE

If you are uninsured or have Medicaid, please complete *Primary Insurance Type* and skip the remaining questions. If you have Medicare or Private insurance, fill in the details below.

<b>Primary Insurance Type:</b> <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private / Other					
<b>Insurance Company Name:</b>			<b>Insurance ID #:</b>		
<b>Subscriber Name:</b>		<b>Subscriber Date of Birth:</b> / /		<b>Relationship to Patient:</b>	
				<input type="checkbox"/> Self	<input type="checkbox"/> Parent/Guardian
				<input type="checkbox"/> Spouse	<input type="checkbox"/> Other: _____
<b>Secondary Insurance Company Name:</b>			<b>Secondary Insurance ID #:</b>		



# ADULT PATIENT REGISTRATION FORM

## HOUSEHOLD INCOME

Collecting this information allows us to offer you discounted services. If you do not know your monthly income, ask us for help.

Number of Household Members (include yourself):

Monthly Household Income (estimated):

\$

## FINANCIALLY RESPONSIBLE PARTY

Individual listed on the patient's account for billing purposes.

Individual Responsible for Bill:  Self

Birth Date:

Social Security #:

/ /

Mailing Address:  Same as above

City:

State:

Zip Code:

Phone Number:  Home  Mobile  Work

## LANGUAGE

What language do you  *speak*  at home:

Interpreter Needed:  Yes  No

English  Spanish  Other: \_\_\_\_\_

If Yes:  Male  Female  No Preference

What language do you  *write*  at home:  English  Spanish  Other: \_\_\_\_\_

## ADDITIONAL INFORMATION

We are a community health center with a mission to serve all regardless of ability to pay or lack of insurance, including individuals and families experiencing homelessness or those employed in agricultural activities.

### Homelessness Status:

- Not Homeless
- At Risk for Homeless
- Transitional Housing
- Permanent Supportive Housing
- Living with Others
- Homeless, Unknown Shelter
- Living in Shelter
- Veteran at Risk for Homeless
- Single Occupancy Hotel
- Street, Camp, Bridge
- Currently Not Homeless, but was in the last 12 Months

**Agricultural Workers:** In the last 2 years, have you or another member of your household worked in any type of agriculture (farm work) that may include: soil prepping, planting, picking, cleaning, sorting, packing, transporting, or work with livestock, etc.?

Yes  No (if no, do not answer the two questions below)

*Migrant* – In the last 2 years, you or a member of your household has lived away from home in order to work in any type of agriculture (farm work). OR in the last 2 years, have you or a member of your household stopped migrating to work in agriculture (farm work) because of a disability or age (too old to work)?

*Seasonal* – In the last 2 years, you or a member of your household do farm work that only happens at certain times throughout the year.

## SIGNATURE & AUTHORIZATION

I authorize Neighborhood Health Center (NHC) to furnish information regarding my medical history, diagnosis, and treatment to my insurance company regarding my claims for benefits. If said insurer fails to meet this obligation or if I am non-insured, I agree to be responsible for any fees related to treatment. I acknowledge I have been provided NHC's Notice of Privacy Practices which explains how my information may be used and/or shared as required/permitted by law. I acknowledge that I have been provided with, and will adhere to, NHC's Patient Rights and Responsibilities. I hereby consent to treatment by NHC professional staff and/or students under direct supervision of licensed NHC clinicians, either at a NHC clinic or via telehealth (i.e., audio and/or video encounter). I understand services will be delivered to me in my preferred language of understanding and that consent to treatment is effective 12 months beyond the date of signature. I hereby give my consent for treatment by NHC and understand that I may cancel this consent at any time, in writing.

\_\_\_\_\_  
*Patient / Guardian Signature*

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



# DENTAL HEALTH HISTORY

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## DENTAL HISTORY

1. Is this your first visit to a dentist?  Yes  No
2. Do you have dental pain, bleeding gums, or sensitive teeth?  Yes  No
3. Have you ever had an injury to your face or jaw or do you have jaw pain?  Yes  No
4. Have you ever had an adverse reaction to materials, medications, or anesthetic used during a dental visit?  Yes  No
5. Do you brush and floss your teeth and mouth daily?  Yes  No
6. Do you currently, or have you ever used tobacco, alcohol, or recreational drugs?  Yes  No  
If yes, please explain: \_\_\_\_\_
7. Do you use fluoride tablets or rinses?  Yes  No
8. What type of dental treatment do you feel you need? \_\_\_\_\_

## MEDICAL HISTORY

The following information is necessary for you to receive dental treatment and will be completely confidential. Dental treatment will not be refused because of existing medical conditions.

1. Are you receiving any type of medical treatment or have you been hospitalized?  Yes  No
2. Have you had a recent illness or surgery?  Yes  No
3. Are you taking any prescription, non-prescription, or herbal medications?  Yes  No  
If yes, list them: \_\_\_\_\_
4. Are you allergic to any medications or to latex?  Yes  No  
If yes, list them: \_\_\_\_\_
5. Have you ever had excessive bleeding requiring medical treatment?  Yes  No
6. If female, are you pregnant?  Yes  No  
If yes, when are you due? \_\_\_\_\_
7. What is your height and weight? Height: \_\_\_\_ ft \_\_\_\_ in Weight: \_\_\_\_\_ lbs

8. Indicate which of the following you have had or have at present. Please check the box.

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Alcoholism               | <input type="checkbox"/> Clotting Disorder       | <input type="checkbox"/> Heart Murmur/Prosthetic Heart Valve/Endocarditis | <input type="checkbox"/> Pacemaker                      |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> History of Blood Transfusion                     | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> HIV/AIDS   | <input type="checkbox"/> Sickle Cell Anemia             |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Drug Addiction          | <input type="checkbox"/> Hypertension                                     | <input type="checkbox"/> Sinus Problems                 |
| <input type="checkbox"/> Arthritis/Joint Disorder | <input type="checkbox"/> Emphysema/COPD          | <input type="checkbox"/> Kidney Disease                                   | <input type="checkbox"/> Sexually Transmitted Infection |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> ED Drug Therapy         | <input type="checkbox"/> Liver Disease/Hepatitis                          | <input type="checkbox"/> Stomach Ulcers                 |
| <input type="checkbox"/> Autism                   | <input type="checkbox"/> Fainting/Dizziness      | <input type="checkbox"/> Mental Health Disorder                           | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Broken Jaw               | <input type="checkbox"/> Glaucoma/Cataracts      | <input type="checkbox"/> Myocardial Infarction (Heart Attack)             | <input type="checkbox"/> Thyroid Disease                |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Heart Disease/Surgery   | <input type="checkbox"/> Organ Transplant                                 | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Chest Pain/Angina        | <input type="checkbox"/> Heart Failure           | <input type="checkbox"/> Osteoporosis / Bisphosphonate Drugs              | <input type="checkbox"/> None of the Above              |

9. Do you have any disease, condition, or problem not listed above?  Yes  No  
If yes, please explain: \_\_\_\_\_

I certify that the information given is complete and correct. Any necessary treatment is hereby authorized.

Patient or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



## COMMUNICATION PERMISSIONS FOR PROTECTED HEALTH INFORMATION (PHI)

*Patients who are minors (under age 18) may request certain levels of confidentiality and consent to various health care matters depending on their age. Further details regarding this can be provided by NHC staff.*

<b>Patient Name:</b> _____		<b>Date of Birth:</b> _____
<b>IT IS OK FOR NEIGHBORHOOD HEALTH CENTER TO CONTACT YOU? (please check all that apply):</b>		
1. Can we send bills to your address?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Can we send automated appointment reminders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, which type?	<input type="checkbox"/> Phone call	<input type="checkbox"/> Text message
3. Can we send you newsletters via email?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Can we call you regarding your visit/treatment with us? Types of calls that could be made:		
Primary Care (lab Results, medical instructions, referrals, medications, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dental Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Behavioral Health (follow up on concerns, referrals, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reproductive Health (sexual health, STI treatment, test results)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Preferred Communication:</b> <input type="checkbox"/> Do not contact <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email via MyChart <input type="checkbox"/> No preference <input type="checkbox"/> Text		
<b>WHO MAY WE SPEAK TO REGARDING YOUR HEALTHCARE? (NOTE: this is not an authorization to release records):</b>		
I authorize Neighborhood Health Center to speak to the following people, in person or by telephone:		<input type="checkbox"/> Not Applicable
<b>Name:</b> _____	<b>Relationship:</b> _____	
<b>Home #:</b> _____	<b>Work #:</b> _____	<b>Mobile #:</b> _____
<b>Preferred Language:</b> _____		<b>Interpreter Needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Use this person as an emergency contact		<input type="checkbox"/> Authorized to sign on behalf of guardian in guardian's absence
Regarding (please check all that apply):		<input type="checkbox"/> Schedule / cancel appointment
<input type="checkbox"/> Prescription drug information	<input type="checkbox"/> Lab results	<input type="checkbox"/> Medical instruction / advice
<input type="checkbox"/> All information	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Imaging results
<b>Name:</b> _____	<b>Relationship:</b> _____	
<b>Home #:</b> _____	<b>Work #:</b> _____	<b>Mobile #:</b> _____
<b>Preferred Language:</b> _____		<b>Interpreter Needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Use this person as an emergency contact		<input type="checkbox"/> Authorized to sign on behalf of guardian in guardian's absence
Regarding (please check all that apply):		<input type="checkbox"/> Schedule / cancel appointment
<input type="checkbox"/> Prescription drug information	<input type="checkbox"/> Lab results	<input type="checkbox"/> Medical instruction / advice
<input type="checkbox"/> All information	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Imaging results
<b>PLEASE LIST LEGAL REPRESENTATIVE, GUARDIAN, POWER OF ATTORNEY, ETC. IF ANY (please provide proof)</b>		
<b>Name:</b> _____		<input type="checkbox"/> Not Applicable
<b>Relationship:</b> _____	<b>Phone:</b> _____	
<b>SIGNATURE REQUIRED (below):</b>		
The authorization may be changed or revoked in writing at any time. It will remain in effect until one (1) year from the date below. By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.		
_____ <i>Signature (Patient/Legal Guardian)</i>	_____ <i>Date</i>	
_____ <i>Print Name</i>	_____ <i>Relationship (if not patient)</i>	



# SLIDING FEE DISCOUNT PROGRAM INFORMATION

## WHY SHOULD I SIGN UP FOR THE PROGRAM?

Neighborhood Health Center (NHC) offers discounted services to patients living at or below 200% of the most current Federal Poverty Guidelines (FPG). Eligibility to participate in the program is based only on the patient's household income and family size, as it relates to FPGs. All patients are encouraged to apply, including patients with insurance. Discounts apply to all NHC services provided directly at NHC clinics and those offered in referral. Discounts vary depending on the patient's assigned discount pay class (see Discount Classes A-D in the Monthly Income table below) and the service being used by the patient at the time of appointment (i.e. medical, dental, or behavioral health). Please take a moment to review this information sheet prior to filling out your application. If you have questions, please ask an NHC staff member for assistance.

## WHO SHOULD I INCLUDE IN MY FAMILY SIZE?



NHC defines a family as a group of two or more people living together who are financially supporting one another.

Do NOT include:

- Family members who do not live with you
- Family members who are financially independent

***Still not sure who to include? Ask us!***

## WHAT IS ACCEPTABLE PROOF OF INCOME?

For each member contributing income to the family, attach at least one of the following documents to your application:

- ✓ Two (2) weeks of most recent pay stubs
- ✓ Check stubs from Unemployment Insurance
- ✓ Previous year W-2
- ✓ Previous year completed tax return
- ✓ Government-issued documentation for other non-wage income such as Social Security, Worker's Comp, Cash Assistance, Child Support, Alimony, Veteran's Benefits, Retirement, or Pension
- ✓ Previous three (3) months of bank statements
- ✓ Letter from employer
- ✓ If self-employed: prior year tax return or most recent three (3) months of bank statements

## WHAT DISCOUNT WILL I RECEIVE?

Below is a table displaying the 2023 Federal Poverty Guidelines (FPG). Only patients reporting a family income at or below 200% of FPG will qualify. Columns A through D are eligible for discounted services. Column E (above 200% FPG) must pay in full for charges and will not receive a discount. If you fall within Column E, you are not eligible to participate in the program.

		MONTHLY INCOME									
Discount Class		A		B		C		D		E	
FPG		0-100%		>100-133%		>133-166%		>166-200%		>200%	
Family Size	1	\$0	\$1,215	\$1,216	\$1,616	\$1,617	\$2,017	\$2,018	\$2,430	\$2,431	& Up
	2	\$0	\$1,643	\$1,644	\$2,186	\$2,187	\$2,728	\$2,729	\$3,287	\$3,288	& Up
	3	\$0	\$2,072	\$2,073	\$2,755	\$2,756	\$3,439	\$3,440	\$4,143	\$4,144	& Up
	4	\$0	\$2,500	\$2,501	\$3,325	\$3,326	\$4,150	\$4,151	\$5,000	\$5,001	& Up
	5	\$0	\$2,928	\$2,929	\$3,895	\$3,896	\$4,861	\$4,862	\$5,857	\$5,858	& Up
	6	\$0	\$3,357	\$3,358	\$4,464	\$4,465	\$5,572	\$5,573	\$6,713	\$6,714	& Up
	7	\$0	\$3,785	\$3,786	\$5,034	\$5,035	\$6,283	\$6,284	\$7,570	\$7,571	& Up
	8	\$0	\$4,213	\$4,214	\$5,604	\$5,605	\$6,994	\$6,995	\$8,427	\$8,428	& Up
	9	\$0	\$4,642	\$4,643	\$6,173	\$6,174	\$7,705	\$7,706	\$9,283	\$9,284	& Up
	10	\$0	\$5,070	\$5,071	\$6,743	\$6,744	\$8,416	\$8,417	\$10,140	\$10,141	& Up

*FPG: Federal Poverty Guidelines, published by HHS, effective 1/19/2023*  
*For families/households with more than 10 persons, add \$428 for each additional person*

### EXAMPLE 1

Susan is a single mother of two young children, Susan also cares for her mother, who lives with her and her children. Susan's family size is 4. Susan is the only person in her family earning income. Susan earns \$2,600 per month in income. Susan belongs to Discount Class B.

### EXAMPLE 2

Jose is married to his wife Miranda. They have three young children who live with them. Jose earns \$2,300 per month at his job. Jose's wife earns \$2,700 per month. Together, the couple earns \$5,000 per month. Jose's family size is 5. Jose belongs to Discount Class D.

## WHAT AM I RESPONSIBLE TO PAY?

Once you figure out what Discount Class you belong to (A-D), discounts vary depending on the service you are using at the time of your service. Services are broken into groups and include medical, dental, and behavioral health.

Discounts apply to clinical services. Note that dental and pharmacy supplies and equipment have separate discounts because they are not clinical services.

	A	B	C	D	E
Medical & Clinical Pharmacy Services	\$25	\$35	\$40	\$45	100% of Full Charges
Dental Services*	\$25	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Dental Supplies & Equipment*	50% of Full Charges	50% of Full Charges	60% of Full Charges	70% of Full Charges	100% of Full Charges
Behavioral Health Services	\$5	\$10	\$15	\$20	100% of Full Charges
Pharmacy Dispensed Prescription Fees**	\$5 Dispensing Fee + Discounted Medication Cost	\$8 Dispensing Fee + Discounted Medication Cost	\$10 Dispensing Fee + Discounted Medication Cost	\$12 Dispensing Fee + Discounted Medication Cost	100% of Full Charges

\*\$25 payment expected at the time of service.

\*\*Ask your Pharmacist for a quote on your medications. Call 503-941-3160 for more information.

### EXAMPLE 1

I belong to Discount Class B. I came in today for a medical visit with my Doctor. I am responsible to pay \$35 for my visit. The remainder of my charges will be adjusted by NHC so that \$35 is my only responsibility.

### EXAMPLE 2

I belong to Discount Class C. I came in today for a dental exam and cleaning. The total of these charges was \$300. I am responsible to pay 60% of these charges. The remainder of my charges will be adjusted by NHC so that \$180 is my only responsibility (\$180 = 60% of \$300 charges).

### EXAMPLE 3

I belong to Discount Class A. I came in today for an appointment to discuss my diabetes with a behaviorist. I am responsible to pay \$5 for my visit. The remainder of my charges will be adjusted by NHC so that \$5 is my only responsibility.

### EXAMPLE 4

I belong to Discount Class D. I am diabetic and NHC is going to deliver my insulin medication to my home. My pharmacist told me I will pay a total of \$16 for my insulin. This includes the cost for the medication plus the dispensing fee.



## I NEED MORE INFORMATION

Not sure who to include in your family size? Not sure what to bring to prove your income? Not sure what discount class you will qualify for? Not sure what you will be charged for a specific service?

**Ask the front desk staff at your NHC clinic to answer any additional questions you have.**



# SLIDING FEE DISCOUNT PROGRAM

## APPLICATION

### INSTRUCTIONS

1. In order to receive discounted services, all patients must apply annually for the Sliding Fee Discount Program. Eligibility is based on family size and household income, as it relates to current Federal Poverty Guidelines.
2. Please read the *Sliding Fee Discount Program Information* sheet. If you have additional questions, please ask the front desk.
3. Please fill out the application and return it to Neighborhood Health Center (NHC) with proof of income attached. Don't forget to sign and date your application.
4. If you can't attach proof of income to your application today, please return proof of income to NHC within 30 days of submitting this application.
5. List yourself as the first family member, followed by others. For individuals not earning an income (for example, a child within your family), enter zero (\$0) for their monthly income.

### PERSONAL INFORMATION

<b>Full Name</b>	
<b>Address</b>	
<b>Phone Number</b>	
<b>Today's Date</b>	

### FAMILY MEMBERS

- Family is defined as a group of two or more people living together who are financially supporting one another.
- Report \$0 under 'Monthly Income' for any family members who do not support you financially.

Full Name	Date of Birth	Relationship	Monthly Income (before taxes)
		Self	\$
			\$
			\$
			\$
			\$
			\$
			\$

### IF YOU REPORT ZERO FAMILY INCOME OR A SOURCE OF INCOME THAT CANNOT BE PROVED

How long have you been without a taxable source of income?	<input type="checkbox"/> > 6 months <input type="checkbox"/> 6 months-1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> Over 2 years
Why are you unable to provide proof of income?	

## ATTESTATIONS

*Please read and initial next to each attestation*

	I attest that I have read the <i>Sliding Fee Discount Program Information</i> sheet and understand requirements to participate in the program.
	I understand that discount will not be applied until my application <u>and</u> proof of income are reviewed and accepted by NHC. I understand that if I cannot provide proof of income, discount will not be applied until my request to waive proof of income is reviewed and approved by NHC's Chief Operating Officer or their designee.
	I understand that eligibility in the program is valid one year from the date my application is approved. I understand I must reapply each year to remain in the program.
	I understand that should my income or family size change during my one-year period of eligibility, I will report changes to NHC and reapply for the program.
	I understand that should my insurance prohibit a waiver of my co-pay, the full co-pay will be collected at the time of service. If you are unsure, contact your insurance company.

## SIGNATURE

*I certify that the information stated is true and accurate by signing this form. If false information is used to obtain assistance, I will be removed from the sliding fee discount program.*

<b>Applicant Signature</b>	<b>Date</b>



-----DO NOT WRITE BELOW THIS LINE-----

## OFFICE USE ONLY

Applicant/s Information		Proof of Income Status: A or B	
<b>Patient/s MRN</b>		<b>Monthly Family Income</b> (verified by proof)	\$
<b>Monthly Family Income</b> (from table on pg.1)	\$	<b>Discount Class</b>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
<b>Family Size</b> (from table on pg.1)		<b>Date Verified</b>	
<b>Proof of Income Status at Time of Application</b>	<input type="checkbox"/> A. Yes, proof attached <input type="checkbox"/> B. Pending, 30-day grace period <input type="checkbox"/> C. No, applicant has listed zero or cash source of income, pending approval by COO or designee	<b>Reviewed By</b>	
		Proof of Income Status: C	
<b>Date</b>		<b>Decision</b>	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
<b>Reviewed By</b>		<b>Discount Class</b>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
		<b>Date of Review</b>	
		<b>Signature of COO or Designee</b>	