



Patient Registration/Sliding Fee Application

Patient Name (Last): _____ (First): _____ (Middle): _____

Address: Street: _____

Apt. #: _____ City: _____ Zip: _____

Phone #: Home: _____ Work: _____ Cell: _____

Email Address: _____

Do you have a Social Security Number? Yes No Social Security Number: _____

Date of Birth: ____/____/____ Age: ____

Household Size: _____ (Include all persons living together related by birth, marriage or adoption and residing together, including other relatives such as spouse, partner, children/ grandchildren, siblings, aunts, uncles, and grandparents)

Annual Income: \$ _____ (Gross income of the patient's household before taxes or other deductions. Tips and overtime along with noncash benefits (such as food stamps and housing subsidies) do not count. Assets are excluded for income calculations)

Living Situation:

Own Rent Motel/Hotel Car/Vehicle Halfway House/Shelter Homeless Shelter Transitional Street Permanent Supportive Housing Other: _____

Marital Status:

Single Married Separated Divorced Widowed Domestic Partner

Are you a Veteran? Yes No **Migrant Worker?** Yes No **Are you disabled?** Yes No

What language should your information be provided in? _____

How well do you understand English? Very well Moderate Very little None

1. **Do you have health insurance?** Yes No **Insurance Company:** _____

Policy Number: _____

2. **Do you have Medicaid?** Yes No **Have you applied?** Yes No

Policy Number: _____

I understand that my medical information is confidential. I authorize the exchange of information between CSC/CPHCC and any other providers or organizations only as necessary for treatment, payment or health care operations purposes. Patient rights and confidentiality policies are posted in our waiting room and copies are available on request.

I hereby authorize treatment by CSC/CPHCC: _____

Patient Signature or guardian (if minor): _____ Date: ____/____/____

Name and relationship (if not patient): _____



**CHILDREN'S SERVICE CENTER/CONYNGHAM PRIMARY HEALTH CARE CENTER
SLIDING FEE DISCOUNT PROGRAM APPLICATION / ATTESTATION FORM**

It is the policy of Children's Service Center (CSC)/Conyngham Primary Health Care Center (CPHCC) to provide essential health care services regardless of a patient's ability to pay. Discounts are offered based on your household size and income. In order to comply with Federal regulations and give you a discount on our services, it is necessary for us to collect some required personal information. Please complete the following information that will be kept on file and confidential. This will help 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 that are purchased from outside, including medications, x-rays, laboratory testing, and other services.

Patient Information	Today's Date:
Name:	
Address:	
Date of Birth:	
For Office use Only-Account Number:	

1. Household Size: Include in your "household" all persons living together related by birth, marriage, or adoption and residing together, including other relatives such as spouse, partner, children/grandchildren, siblings, aunts, uncles, and grandparents.

Household Size		
Name	Date of Birth (MM//DD//YY)	Relationship
1.		
2.		
3.		
4.		
5.		
6..		
7.		
8.		

2. Household Income: Gross income of the patient's household before taxes or other deductions. Tips and overtime along with noncash benefits (such as food stamps and housing subsidies) do not count. Assets are excluded for income calculations.

NOTE: Include income from all sources, including gross wages, tips, social security, disability, pensions, annuities, veterans' payments, alimony, child support, unemployment, public aid, military, real estate and rental income, net business or self-employment, etc. If providing paycheck stubs as proof of income, it is required to provide at least 4 weeks of pay (i.e., 4 weekly paychecks or 2 bi-weekly checks) dated within the last 45 days.

Household Income						
Household Member	Frequency (circle one)				Annual Income	Source
	Weekly	Bi-weekly	Monthly	Annual		
You	Weekly	Bi-weekly	Monthly	Annual		
Spouse	Weekly	Bi-weekly	Monthly	Annual		
Other Specify:	Weekly	Bi-weekly	Monthly	Annual		
Other Specify:	Weekly	Bi-weekly	Monthly	Annual		
Other Specify:	Weekly	Bi-weekly	Monthly	Annual		
Other Specify:	Weekly	Bi-weekly	Monthly	Annual		
Other Specify:	Weekly	Bi-weekly	Monthly	Annual		
Other Specify:	Weekly	Bi-weekly	Monthly	Annual		
Other Specify:	Weekly	Bi-weekly	Monthly	Annual		

You will have to complete a new application annually or whenever there is a major change in household income and/or household size.

If you do not have proof of income, this form will serve as your self-attestation until up can provide proof of income.

Attestation: I am affirming that the information provided on this application is true and correct to be the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the Sliding Fee Discount Program and may subject me to penalties under Federal law. I further agree to inform the Children’s Service Center/Conyngham Primary Health Care Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will follow all the guidelines of Children’s Service Center’s/ Conyngham Primary Health Care Center’s Sliding Fee Discount Program. I hereby acknowledge that I read the Sliding Fee Discount Program guidelines, had the chance to ask questions and understand it.

Name: _____ Date: ____/____/____

Signature _____

Verification Checklist-Office Use Only	Yes	No
Identification: Driver’s license, birth cert., social security card, or other		
Proof of income		
If unable to provide, why:		
Total Annual household Income		
Total Household Size:		
Assigned Sliding fee Discount Class(1-6):		
Approved by CSC/CPHCC:		
Effective Date:		
Expiration Date:		