HIGH COUNTRY community health

Application for Sliding Fee Scale

An application for each household is required every 12 months.

Date: _____

Patient Name: _____

Please include all of the following sources of income for the last 12 months for each household member. (Household members who currently live together and share income and expenses.)

All Employment	Alimony Payments	Unemployment
SSI Disability	Retirement Income	Child Support Payments
Work First (TANF)	Social Security Income	Any other Income
Veteran Benefit		

Name	Date Of Birth	Relationship To Patient	Income Source	Gross Income Before Taxes	Frequency Paid	Front Desk Calculated Annual Amount	Front Desk Source of Verification

I certify that the income information given to High Country community Health from me is correct and accurate.

Please initial the following:

_____ Sliding Fee Scale eligibility is effective for all services provided today until 12 months from today. I understand I will need to reapply for the sliding fee scale 12 months from today.

_____ I agree to notify High Country Community Health immediately if my contact or income information changes.

High Country Community Health will not refuse care based on inability to pay.

Responsible Party Signature: _____ Date: _____

Staff Signature: _____ Date: _____

STAFF USE ONLY					
	Household Size:	Annual Gross Income:			
Verified Income:	0 – 100% FPL	101 – 125% FPL	126 – 150% FPL	151 – 200% FPL	>201% FPL

**Staff: Please include income calculations in the margin of this form or on separate sheet of paper and scan it into the patients records with all income verification. **

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School: _____

PATIENT INFORMATION

First Name:_____MI:___Last Name:_____Preferred Name:_____
D.O.B._____Age:_____Birth Sex:__Male__Female SS#:_____-_____-_____

Do you have a medical provider? ☐ Yes ☐ No Name of Provider: _____
Do you have a dental provider? ☐ Yes ☐ No Name of Provider: _____

Street Address: _____

Mailing Address (if different):_____City:_____State:_____Zip code_____

Email Address:_____Phone: Home_____Cell_____Work_____

If patient is a minor: Parent/ guardian 1:_____ Contact information: _____

Parent/ guardian 2:_____ Contact information: _____

Minor lives with: _____

EMERGENCY INFO

Name:_____Relationship:_____Address:_____City, State: _____

Home:_____Cell Phone:_____Work Phone:_____Ext: _____

Race

Asian:
___Asian Indian ____Chinese____Filipino
___ Japanese ____Korean_____Vietnamese
___ Other Asian
Native Hawaiian/Other Pacific Islander:
___Native Hawaiian____Other Pacific Islander
___ Guamanian or Chamorro
____Samoan
___Black/African American
___American Indian ___White
____Decline to Answer

Ethnicity

Hispanic or Latino/a or Spanish:
___Mexican, Mexican American, Chicano/a
____ Puerto Rican_____Cuban
___Another Hispanic, Latino/a or Spanish Origin
___More than one ethnicity
___Non-Hispanic or Latino/a
___Decline to Answer

Preferred Language

___English
___ Spanish
____ American Sign Language
Other: _____

INSURANCE

Insurance Company Name: _____ Policy Number: _____
Guarantor Name: _____ Group Number: _____
Relationship to Student: _____

Other Information

1. Is there a CUSTODY agreement in place? ☐ **Yes** ☐ **No** If so, please provide a copy of the agreement.

2. Has anyone in your household, in the past 2 years, been considered a Seasonal Farmworker? (A person whose source of income is earned mostly in agricultural work, without moving away from home) ☐ **Yes** ☐ **No**

3. Has anyone in your household, in the past 2 years, been considered a Migrant Farmworker? (A person who has moved away from home and established a temporary home in order to work primarily in agriculture) ☐ **Yes** ☐ **No**

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Patient Name: _____ Date of Birth: _____

Consent for Healthcare and Release of Personal Health Information:

I voluntarily consent to healthcare treatment (i.e., Dental, Medical Care, and/or Behavioral Health) from the providers and staff of High Country Community Health (HCCH). I consent to all necessary treatment of illness and injuries and preventative care including screenings, lab work, (including HIV testing), immunizations, and referrals. I am aware that neither the practice of medicine, dental treatment, nor the delivery of mental/behavioral health treatment is an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that HCCH employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between HCCH providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about me for treatment, payment, and healthcare operations. I understand that my medical information could include medical history or information regarding diagnosis and treatment for communicable disease (such as sexually transmitted infection, HIV/AIDS or hepatitis), mental illness, alcohol or substance use. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Title's V, XVIII, and/or XIX of the Social Security Act is correct. I certify that I have read and understand this form. I understand that I am automatically enrolled in the Health Information Exchange, but at any time can op-out by visiting www.highcountrycommunityhealth.com and completing the Opt-out form. I understand that North Carolina Statutes Section 90-21.5 protects a minor's rights to receive services relating to sexually transmitted disease, pregnancy, drug abuse and emotionally disturbances without parental consent. I understand that according to NC General Statutes 90-21.4 medical providers are not required to notify me about services provided in these areas unless the situation indicates that notification is essential to the life or health of the minor. I understand that if I request information about these services, the medical provider will share information with me only if the provider considers it in the best interest of my child's health and welfare to do so. This consent is renewable annually. I may withdraw authorization for services at any time. Initial ____

HIPAA Notice of Privacy Practice Acknowledgement:

We are required, upon request, by law to provide you with our HIPAA Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you as follows: by visiting www.highcountrycommunityhealth.com, or by requesting one at any HCCH location.
Initial _____

Financial Responsibility and Assignment of Insurance Benefits:

I understand that for my convenience HCCH accepts Cash, Checks (no starter checks), Visa, MasterCard, Discover or Care Credit (dental only). I also understand that HCCH files with Medicaid, Medicare and many private insurance companies. I authorize my insurance benefits to be paid to HCCH. It is my responsibility to check that HCCH is in network with my private/dental insurance prior to my first appointment. Co-pays are due and collected at the time the services are rendered. If for any reason my insurance company does not pay its estimated portion the balance will be my responsibility. I agree to promptly pay for any balance not covered be insurance. I understand that there may be additional charges including, but not limited to, health screening, behavioral health services, nutritional services, dental services, vaccines and injections. Labs sent to outside laboratories (e.g., LabCorp, Wake Forest Labs or Quest) will be billed separately and are not a part of HCCH. A separate bill from the lab company will arrive by mail. A copy of my Driver's License/Photo ID is required for every patient along with a copy of your Medical/Dental Insurance Card or Medicaid Card. High Country Community Health also providers a Sliding Fee Scale payment option for all our patient. Proof of income and household size are required to qualify. Initial _____

I understand that if I am 18 years of age or older, I may consent for health services; otherwise my parent or legal guardian will need to consent for services.

_____ _____
Signature of Patient or Authorized Person Date

_____ _____
Insured Party of Financial Guarantor (if different from above) Date