ES 03-30-2011

Mountain Comprehensive Health Corporation

REGISTRATION FORM

Today's date:	Whitesburg	Harlan	Leatherwood/ Blackey	Owsley County	Buckhorn

PATIENT INFORMATION *PLEASE COMPLETE ALL INFORMATION*

Last Name:	First Name:	Middle:	Previous Last Name:	Nickname:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security # - -	Date of Birth: / /	Sex: ❑ M ❑ F

Mailing Address:	City:	State:	ZIP Code:
Physical Address:	City:	State:	ZIP Code:

Language: ❑ English ❑ Spanish ❑ Other:	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated	Student Status: ❑ Full-Time ❑ Part-Time

Home Phone: ( )	Daytime Phone: ( )	Alternate Phone: ( )

E-mail address:

Are you employed? ❑ Full Time ❑ Part Time ❑ Unemployed ❑ Self ❑ Retired ❑ Active Duty	Employer Name: Employer Address:	Employer Phone: ( )

UDS INFORMATION *MCHC RECEIVES MONEY FROM THE FEDERAL GOVERNMENT TO HELP PROVIDE MEDICAL SERVICES TO DEFINED POPULATIONS BASED ON THE INFORMATION BELOW. BY PROVIDING THIS INFORMATION, YOU HELP US CONTINUE TO RECEIVE THIS MONEY SO WE CAN CONTINUE TO PROVIDE QUALITY HEALTH CARE SERVICES. WE APPRECIATE YOUR HELP!*

Are you Homeless? ❑ Yes ❑ No

If so, what describes your current situation? ❑ Staying with Friends/ Family ❑ Shelter ❑ Street ❑ Transitional

Do you need an Interpreter? ❑ Yes ❑ No

Are you a Migrant Farm Worker? ❑ Yes ❑ No

If so, what describes your current situation? ❑ Migrant ❑ Seasonal

Race:

❑ White ❑ Black/ African American ❑ American Indian/ Alaskan Native ❑ Asian ❑ Native Hawaiian/ Pacific Islander ❑ More Than One Race

Ethnicity: ❑ Hispanic ❑ Not Hispanic	Veteran: ❑ Yes ❑ No	Number in Household:	Annual Household Income: $

RESPONSIBLE PARTY *WHO IS THE PERSON RESPONSIBLE FOR PAYING FOR TODAY'S BILL?*

❑ Self ❑ Spouse ❑ Parent ❑ Other

Name:

Mailing Address:

Physical Address:

Home Phone: ( )	Social Security # - -	Date of Birth: / /

REVIEWED BY / DATE REVIEWED BY / DATE REVIEWED BY / DATE REVIEWED BY / DATE REVIEWED BY / DATE

INSURANCE *WHICH INSURANCE SHOULD BE BILLED FOR TODAY'S VISIT?*
❑ **I DO NOT HAVE INSURANCE**
PRIMARY INSURANCE: ❑ WORKERS COMP:________________________
❑ MEDICARE ❑ KY MEDICAID ❑ HUMANA ❑ ANTHEM ❑ AETNA ❑ BLUEGRASS FAMILY HEALTH ❑ OTHER:
SECONDARY INSURANCE: ❑ WORKERS COMP:________________________
❑ MEDICARE ❑ KY MEDICAID ❑ HUMANA ❑ ANTHEM ❑ AETNA ❑ BLUEGRASS FAMILY HEALTH ❑ OTHER:

YOU MAY QUALIFY FOR A DISCOUNT!!!

Please review the chart below.
If your Income to Family Size Ratio falls in Column A, B, C, or D you may be eligible for the MCHC Sliding Scale.
To verify eligibility, please sign the appropriate box below and ask your MCHC Receptionist.

FAMILY SIZE AND INCOME	***FIRST FIND AND CIRCLE YOUR FAMILY SIZE. THEN GO ACROSS THAT LINE, FIND AND CHECK THE YEARLY INCOME RANGE FOR YOUR FAMILY.***				
	A	**B**	**C**	**D**	**E**
Family Size **1**	❑ $0 - $10,890	❑ $10,890 - $13,613	❑ $13,613 - $16,335	❑ $16,335 - $21,780	❑ $21,780 - above
Family Size **2**	❑ $0 - $14,710	❑ $14,710 - $18,388	❑ $18,388 - $22,065	❑ $22,065 - $29,420	❑ $29,420 - above
Family Size **3**	❑ $0 - $18,530	❑ $18,530 - $23,163	❑ $23,163 - $27,795	❑ $27,795 - $37,060	❑ $37,060 - above
Family Size **4**	❑ $0 - $22,350	❑ $22,350 - $27,938	❑ $27,938 - $33,525	❑ $33,525 - $44,700	❑ $44,700 - above
Family Size **5**	❑ $0 - $26,170	❑ $26,170 - $32,713	❑ $32,713 - $39,255	❑ $39,255 - $52,340	❑ $52,340 - above
Family Size **6**	❑ $0 - $29,990	❑ $29,990 - $37,488	❑ $37,488 - $44,985	❑ $44,985 - $59,980	❑ $59,980 - above
Family Size **7**	❑ $0 - $33,810	❑ $33,810 - $42,263	❑ $42,263 - $50,715	❑ $50,715 - $67,620	❑ $67,620 - above
Family Size **8**	❑ $0 - $37,630	❑ $37,630 - $47,038	❑ $47,038 - $56,445	❑ $56,445 - $75,260	❑ $75,260 - above
Family Size **9**	❑ $0 - $41,450	❑ $41,450 - $51,813	❑ $51,813 - $62,175	❑ $62,175 - $82,900	❑ $82,900 - above
Family Size **10**	❑ $0 - $45,270	❑ $45,270 - $56,588	❑ $56,588 - $67,905	❑ $67,905 - $90,540	❑ $90,540 - above

INTERESTED IN SLIDING SCALE

The guidelines for the MCHC Sliding Scale Policy have been explained to me and I have reviewed the income level qualifications. I would like more information in applying for the Sliding Scale program

X______________________________________ ____________________

Patient Signature Date

NOT INTERESTED IN SLIDING SCALE

The guidelines for the MCHC Sliding Scale Policy have been explained to me and I have reviewed the income level qualifications. At this time, I do not qualify for the program or otherwise do not wish to apply.

X______________________________________ ____________________

Patient Signature Date

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )