CROSSROADS HEALTHCARE CLINIC

100 Central Avenue
Cheyenne, WY 82007
(307) 632-8064

Agency Use: Homeless or Housed
Income/Insured
Above 100% of poverty guidelines? Y N (if no, nominal fee is charged)
Above 101%-Sliding Fee Scale Determination: Today's payment? _____ per office visit/medications? _____
Sliding fee scale explained to patient? Y N
Copy of ID? Y N
Initial self-attestation and eligibility determined by:
Staff Signature: _____
Date:

Last Name	First Name (Legal)	Middle Name	Phone Number

Address	City	State	Zip Code

Sex at Birth: ☐ Male ☐ Female	Birth Date	Social Security Number	Age

Marital Status (check one):	Email Address:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	

Gender Identity: (check one)

☐ Male ☐ Female ☐ transgender Male/Female-to-male ☐transgender Female/Male-to-female

☐ Other ☐ Choose not to disclose

Patients by sexual orientation:

☐ Lesbian or gay ☐ straight ☐ Bisexual ☐ Something else ☐ Don't Know ☐ Choose not to disclose

Race (check one):

☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native

☐ White ☐ More than one race ☐ Unreported/refused to report race

Ethnicity:

☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Unreported/Refused to report ethnicity

Housing Information (check one): ☐ Homeless in last 12 months	Primary Language (check one):
☐ Homeowner ☐ HUD/CHA ☐ Public Housing ☐ Homeless ☐ Renter	☐ English ☐ Other_____
☐ Rent Free ☐ Relocating	☐ Spanish

If you do not own, rent, or receive housing assistance where do you live? (check one)

☐ Street ☐ Shelter ☐ Doubled-Up ☐ Transitional Living ☐ SRO ☐ Other_____

Employment (check one):

☐ Full Time ☐Part Time ☐ Unemployed ☐ Student Are you a veteran? (check one): No ☐ Yes ☐

Insurance: ☐ Yes ☐ No Name on Insurance:_____ Policy#_____

Group Id#:_____ Dual Insured Medicare/Medicaid Seasonal /Migrant Worker ☐ Yes ☐ No

Are you covered by any of the following forms of insurance?		Do you or any member of your household receive any following?	
a) Private Insurance	No ☐ Yes ☐	a) Food Stamps	No ☐ Yes ☐
b) Medicare A B D	No ☐ Yes ☐	b) Housing Assistance	No ☐ Yes ☐
c) Equality Care Card (Medicaid)	No ☐ Yes ☐	c) WIC	No ☐ Yes ☐
d) Kid Care/CHIP	No ☐ Yes ☐	d) CHA Utility Allowance	No ☐ Yes ☐
e) Prescription Coverage	No ☐ Yes ☐	e) TANF	No ☐ Yes☐
f) VA Benefits	No ☐ Yes ☐		

Emergency Contact: Phone # Relationship :

# of Household members	**Please circle your current income or write zero on the line, if you have income you must bring income verification at your next visit. If your household is larger please see staff. Monthly Income Amount $_____x 12 = _____ Please Circle: Employment/SSI/Other**										
1	12,140	12,140	12,141	15,175	15,176	18,210	18,211	21,245	21,246	24,280	24,281
2	16,460	16,460	16,461	20,575	20,576	24,690	24,691	28,805	28,806	32,920	32,921
3	20,780	20,780	20,781	25,975	25,976	31,170	31,171	36,365	36,367	41,560	41,561
4	25,100	25,100	25,101	31,375	31,376	37,650	37,651	43,925	43,926	50,200	50,201

To help with access to care, Crossroads Healthcare Clinic patients can self-attest (self-report) household size and income on the ***first visit***. **I understand that I will be required to verify income in order to participate in the ongoing sliding fee scale program.** The sliding fee scale program allows our clinic to offer health care to you and our community at an affordable cost. **If Crossroads staff has not verified your income after the second visit, you are not eligible to participate in our sliding fee scale program and will be charged 100% of the fee schedule for services provided at our health clinic.** We can use letters from the shelter or treatment program, 30 day paystubs, doubled up verification forms, food stamp print outs, or tax returns for income verification.

My signature indicates that all of the information I have provided is complete and accurate to the best of my knowledge. I hereby grant permission to this agency to obtain and share the information I have provided for the purpose of determining eligibility for assistance.

X_____ _____

Signature (Applicant or Head of Household) Date

Confidentiality and Service Agreement. All information obtained in any discussion with the clinical staff will be kept confidential. Only in you sign a release for the information to be given to a specific person or agency, will this information be shared. The clinic will provide you with case management services, community referrals and other support services within the community. The clinic will also help with emergency transportation issues. The clinic provides comprehensive medical care.

Acknowledgement of Receipt of Notice of Privacy Practices. The notice of Privacy Practices explains how your protected health information may we used or disclosed by us. In addition, it explains your rights with regard to your patient information as well as our legal responsibilities. By signing below, you are acknowledging that the Notice of Privacy Practices has been provided to you.

I received the Notice of Privacy Practices for Crossroads Healthcare Clinic.

_____ _____

Signature of Patient of Parent/Legal Guardian Date

Acknowledgement of Patient Responsibility. I have been provided with a copy of Crossroads Healthcare Clinic patient responsibilities and I understand my patient responsibilities. I have been given the opportunity to have my questions answered regarding the patient responsibilities.

_____ _____

Signature of Patient of Parent/Legal Guardian Date

Consent for Treatment

I, _____, hereby consent to receive evaluation and treatment from Crossroads Healthcare Clinic.

_____

Print Name of Patient or Parents/Legal Guardian

_____ _____

Signature of Patient of Parents/Legal Guardian Date

_____ _____

Signature of Witness Date