



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
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Address	City	State	Zip Code
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Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	Social Security Number	Age
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Marital Status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Email Address:
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**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): <input type="checkbox"/> Homeless in last 12 months <input type="checkbox"/> Homeowner <input type="checkbox"/> HUD/CHA <input type="checkbox"/> Public Housing <input type="checkbox"/> Homeless <input type="checkbox"/> Renter <input type="checkbox"/> Rent Free <input type="checkbox"/> Relocating	Primary Language (check one): <input type="checkbox"/> English <input type="checkbox"/> Other _____ <input type="checkbox"/> Spanish
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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?

- a) Private Insurance No  Yes
- b) Medicare A B D No  Yes
- c) Equality Care Card (Medicaid) No  Yes
- d) Kid Care/CHIP No  Yes
- e) Prescription Coverage No  Yes
- f) VA Benefits No  Yes

Do you or any member of your household receive any following?

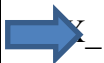
- a) Food Stamps No  Yes
- b) Housing Assistance No  Yes
- c) WIC No  Yes
- d) CHA Utility Allowance No  Yes
- e) TANF No  Yes

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										
	12,140	12,140	12,141	15,175	15,176	18,210	18,211	21,245	21,246	24,280	24,281
1											
2											
3											
4											

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.*



\_\_\_\_\_  
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