A PROGRAM OF COMMUNITY ACTION OF LARAMIE COUNTY

Agency use Only: Homeless or Housed

Above 100% of poverty guidelines? ☐ Yes ☐ No

Above 101% Sliding Fee Scale: Office Visit________ Medication_______

Sliding fee scale explained to patient? ☐ Yes ☐ No **Copy of ID?** ☐ Yes ☐ No

Initial self- attestation and eligibility determined by: *Staff Signature:* __________________________ *Date:*__________

Reason for Visit:

____

Last Name______________________ **First Name**_________________________ **Middle Name**_____________________

Address:_______________________________________**City:**______________ **State:**___________ **ZipCode:**__________

Phone Number: ___________________________ **Okay to leave a message?** ☐ Yes ☐ No

Sex at Birth: ☐ Male ☐ Female **Date of Birth:**_______________ **Age:**______ **Social Security#:**______________________

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

Email Address: ____

Gender Identity (Check one): ☐ Male ☐ Female ☐ Transgender Female to male ☐ Transgender male to Female

☐ Other ☐ Choose not to disclose

Sexual Orientation: ☐ Straight ☐ Bisexual ☐Lesbian or Gay ☐ Something else ☐ Don't know ☐Chose not to disclose

Race (check one): ☐White ☐Asian ☐Native/Hawaiian ☐Black/African American ☐American Indian/Alaska Native

☐ More than one race ☐ Unreported/chose not to report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Housing Information (check one): ☐ Homeowner ☐ Public Housing ☐ Homeless ☐ Rent ☐ Rent Free ☐ Relocating

Have you been homeless in the last 12 months ☐ Yes ☐ No

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 ☐ Seasonal Migrant worker

Primary Language: ☐ English ☐ Spanish ☐ Other__________

Are you a student: ☐ Yes ☐ No **Are you a Veteran:** ☐ Yes ☐ No

Emergency Contact Name: First _________________________ **Last**____________________________

Number:____________________________ **Relationship:**_______________________ **Ok to leave a message?** ☐Yes ☐No

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

☐ Food Stamps ☐ Housing Assistance ☐ WIC ☐ CHA Utility Allowance ☐ TANF

Insurance: ☐ Yes ☐ No **Insurance Company:** ________________________________

Name on Insurance Card:__________________________ **Relationship to Insured:**________________________

Policy#:___________________________**Group ID #:**___________________________

Dual Insured Medicare/Medicaid: ☐Yes ☐ No

Finances: Do you receive SSI: ☐ Yes ☐ No Do you receive money from other source: ☐ Yes ☐ No

Total monthly income: $_____________________x 12=____________________

<u>If you have income, you must bring income verification at your next visit.</u>

Number of people in your household: ____________

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. This sliding fee scale program allows our clinic to offer health care to you and out 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 out clinic. We can use letters from the shelter or treatment program, 30-day paystubs, double 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.

Printed Name: __________________________________ **Relationship to Patient:**_____________________________

Signature:____________________________________ **Date:**___________________

Sliding fee Discount Application

NAME OF HEAD OF HOUSEHOLD:______________________________**PLACE OF EMPLOYMENT:**______________________

Please list spouse and dependents under age of 18.

Self:________________________________ D.O.B:________ Dependent:_________________________ D.O.B:________

Spouse:_____________________________ D.O.B:________ Dependent:__________________________ D.O.B:________

Dependent:__________________________ D.O.B:________ Dependent:__________________________ D.O.B:________

Dependent:__________________________ D.O.B:________ Dependent:__________________________ D.O.B:________

Annual Household Income

Source	**Self**	**Spouse**	**Other**	**Total**
Gross wages, Salaries, Tips, Etc.				
Income from business, self-employment and dependents.				
Unemployment compensation, Workers' compensation, Social Security, Supplemental Security Income, Public Assistance, Veterans' Payments, Survivor Benefits, Pension or Retirement Income.				
Interest, Dividends, Rents, Royalties, Income from estates, Trusts, Educational assistance, Alimony, Child Support, Assistance from outside the household and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I Certify that the family size and income information shown above is correct.

Print Name:_______________________________**Signature:**________________________________**Date:**______________

Self-Attestation Form

Name: ____ **DOB:**______________________ **Date:**_____________________

Address: ______________________________________**City, State, Zip:**____

On this date, I certify that my total household income is:____

Please check one of the following:

_____ I will provide proof of income (Pay stub, Tax return, or Food stamp printout) by my next visit.

_____ I am unable to provide proof of income: ____

_____ I have not had income for the past _______________ Months/Years. I have supported myself during this period of time as follows:

____

____

____

By Signing this form, I certify that all of the information I have provided is complete and accurate to the best of my knowledge.

Signature:____ **Date:** _______________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

The notice of privacy practices explains how your protected health information may be used or disclose by us. In addition, it explains your rights with regard to your patient information as well as out legal responsibilities. By initialing this form, you are acknowledging that the Notice of Privacy Practices has been provided to you.

Initial: _________

Acknowledgement of Patient Responsibility

The patient responsibilities exit to allow us to provide the best possible care. By initialing this form, you are acknowledging that the patient responsibilities has been provided to you.

Initial: _________

Consent for treatment

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

Printed name of Patient or Legal Guardian:____

Signature of Patient or Legal Guardian:____

Date: ____________________

Printed Name & Signature of Witness:____

Date: ____________________

Patient Responsibilities

The staff at Crossroads Healthcare Clinic warmly welcomes you and look forward to serving your healthcare needs. In order to best serve you, there are several requirements and responsibilities that must be met on your part. Please read the information below carefully and if you have any questions, please ask a staff member for clarification.

You have the responsibility to be considerate and courteous to other patients and Crossroads healthcare Clinic staff.

You have the responsibility and the right to participate in decisions related to your care.

You have the responsibility to be open and Honest with us about instructions you receive concerning your health Let us know immediately if you do not understand them, feel you cannot follow them.

You are responsible to bring with you information about past illnesses, hospitalizations, medications, and other matters related to your health and/or social history.

You are responsible to be on time for scheduled appointments or contact us if you cannot make the appointment.

Crossroads Healthcare Clinic is established to provide care for the homeless and non-homeless population of Laramie County. The services of this clinic are provided at a greatly reduced cost and as a result, we will need your help with our sliding fee scale application and income and housing verifications. Crossroads Healthcare Clinic is not a free clinic.

For those on the sliding fee program and are below 100% of federal poverty, our nominal fee of $7.00 (or your insurance co-pay amount) is asked for at each appointment. No emergency or urgent care will be denied if you are unable to make your payment.

We request proof of income (or lack thereof) from each patient. If you are working, we will need 30-day paystubs or tax return from previous year. If you have no income, we can use letters from the shelter or treatment centers, self - attestation form, doubled up verification form or a food stamp print out. If you have no income, we will ask you to write a treatment about your current situation.

Giving false information is considered fraud.

By signing below, I acknowledge that I have read or have had read to me the above information and I understand my responsibilities. I have been given the opportunity to have my question answered regarding the above patient responsibilities.

____ ____________________

Signature of Patients or Parent/Legal Guardian Date