Med Rec# _____

YNHS 2015 PATIENT REGISTRATION / SLIDING FEE APPLICATION AND CONSENT FOR CARE

Patient Name _____ DOB ____/____/_____
Social Security # _____--____--_____ Other Names You Go By: _____
Current Address _____
Street / PO Box City Zip
Daytime Phone _____ Message#_____ Who is this? _____
Email Address _____
Preferred Contact: Mail Phone **Message OK ?** YES NO | **OK to Mail things to your home ?** Yes No

Please tell us about your living situation. All information is CONFIDENTIAL:

___ I / we have been homeless in the last year and have housing now (Transitional)
___Staying with friends/relatives (Doubling Up, Sofa Surfing)
___Staying in a shelter (Short term housing like the Mission, YWCA, Calvary, New Hope, etc.)
___Staying in a treatment facility (Transitional)
___Living in public housing (apartments or duplexes) where all the tenants get discounted rent .
___Living on the street, outdoors, or in a car/travel trailer/camper (Street)
___Living somewhere not meant to be a home – no running water or heat (Other homeless)
___We have concerns about our housing and want to discuss this with a supervisor in private. (Other)
___We own / rent our own home without help. Our housing situation is stable.

Is the Patient Hispanic (circle) ? Yes No **Is the Patient a Smoker ?** Yes No

PATIENT RACE(circle): Asian Native Hawaiian Other Pacific Islander
African American/Black American Indian/ Alaska Native White Multi-Racial

IF 18 or Older, HAS THE PATIENT BEEN IN THE MILITARY ? (circle)? Yes No

Is there anyone (family / friend) you want to give our providers permission to talk to about your medical / dental condition(s)?
Name _____ Relationship _____
Name _____ Relationship _____

What kind of Medical Coverage do you have? (We'll need to make a copy of your card)
Apple Health /Healthy Options Medicare Private Insurance None
Other _____
Do You Receive (circle): Basic Food WIC VA Benefits SSI
(This information tells us if you qualify for medical, dental, or pharmacy discounts):
Current Household Monthly Income $_____ . How many people live in your household? _____
Is your Household Income dependent Migrant Farm Work? **YES NO** (circle) Seasonal Farm Work? **YES NO** (circle)

- ☐ I give my permission for the above named patient to receive treatment which the attending medical or dental practitioner considers necessary.
- ☐ I understand my financial obligation. If I have insurance (including Medicaid and Medicare) I authorize my insurance company or payor of services, to obtain information from YNHS for the purpose of determining payment for my care. If I do not have insurance, I understand my ability to pay has been determined based on the information I have given to YNHS staff on this form. I understand I may be charged a fee if I fail to keep my scheduled appointment and do not cancel before the scheduled appointment time. I understand my insurance (including Medicaid and Medicare) will not pay this for me.

_____ _____
Signature of patient/guardian date Staff Signature / Interpretation needed? Y N date

2015 PATIENT REGISTRATION / SLIDING FEE APPLICATION/ CONSENT FOR CARE
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Patient Name _____ Medical Record # _____

Current Household Monthly Income $_____ . How many people live on this income? _____

HHSiz	0-100% FPL			101-125% FPL			126-150% FPL			151-200% FPL			201% FPL
1 yr	$ -	-	$ 11,770	$ 11,771	-	$ 14,713	$ 14,714	-	$17,655	$17,656	-	$ 23,540	$ 23,541
1 mo	$ -	-	$ 981	$ 982	-	$ 1,226	$ 1,227	-	$ 1,471	$ 1,472	-	$ 1,962	$ 1,963
2 yr	$ -	-	$ 15,930	$ 15,931	-	$ 19,913	$ 19,914	-	$23,895	$23,896	-	$ 31,860	$ 31,861
2 mo	$ -	-	$ 1,328	$ 1,329	-	$ 1,659	$ 1,660	-	$ 1,991	$ 1,992	-	$ 2,655	$ 2,656
3 yr	$ -	-	$ 20,090	$ 20,091	-	$ 25,113	$ 25,114	-	$30,135	$30,136	-	$ 40,180	$ 40,181
3 mo	$ -	-	$ 1,674	$ 1,675	-	$ 2,093	$ 2,094	-	$ 2,511	$ 2,512	-	$ 3,348	$ 3,349
4 yr	$ -	-	$ 24,250	$ 24,251	-	$ 30,313	$ 30,314	-	$36,375	$36,376	-	$ 48,500	$ 48,501
4 mo	$ -	-	$ 2,021	$ 2,022	-	$ 2,526	$ 2,527	-	$ 3,031	$ 3,032	-	$ 4,042	$ 4,043
5 yr	$ -	-	$ 28,410	$ 28,411	-	$ 35,513	$ 35,514	-	$42,615	$42,616	-	$ 56,820	$ 56,821
5 mo	$ -	-	$ 2,368	$ 2,369	-	$ 2,959	$ 2,960	-	$ 3,551	$ 3,552	-	$ 4,735	$ 4,736
6 yr	$ -	-	$ 32,570	$ 32,571	-	$ 40,713	$ 40,714	-	$48,855	$48,856	-	$ 65,140	$ 65,141
6 mo	$ -	-	$ 2,714	$ 2,715	-	$ 3,393	$ 3,394	-	$ 4,071	$ 4,072	-	$ 5,428	$ 5,429
7 yr	$ -	-	$ 36,730	$ 36,731	-	$ 45,913	$ 45,914	-	$55,095	$55,096	-	$ 73,460	$ 73,461
7 mo	$ -	-	$ 3,061	$ 3,062	-	$ 3,826	$ 3,827	-	$ 4,591	$ 4,592	-	$ 6,122	$ 6,123
8 yr	$ -	-	$ 40,890	$ 40,891	-	$ 51,113	$ 51,114	-	$61,335	$61,336	-	$ 81,780	$ 81,781
8 mo	$ -	-	$ 3,408	$ 3,409	-	$ 4,259	$ 4,260	-	$ 5,111	$ 5,112	-	$ 6,815	$ 6,816
9 yr	$ -	-	$ 45,050	$ 45,051	-	$ 56,313	$ 56,314	-	$67,575	$67,576	-	$ 90,100	$ 90,101
9 mo	$ -	-	$ 3,754	$ 3,755	-	$ 4,693	$ 4,694	-	$ 5,631	$ 5,632	-	$ 7,508	$ 7,509
10 yr	$ -	-	$ 49,210	$ 49,211	-	$ 61,513	$ 61,514	-	$73,815	$73,816	-	$ 98,420	$ 98,421
10 mo	$ -	-	$ 4,101	$ 4,102	-	$ 5,126	$ 5,127	-	$ 6,151	$ 6,152	-	$ 8,202	$ 8,203
Ea yr	$ -	-	$ 4,160	$ 4,161	-	$ 5,200	$ 5,201		$ 6,240	$ 6,241	-	$ 8,320	$ 8,321
Ea mo	$ -	-	$ 347	$ 348	-	$ 433	$ 434		$ 520	$ 521	-	$ 693	$ 694

Reception / Intake Staff :

(yes or n/a)

Uninsured patients / IPA scheduled _____

Patient Portal - Token Given /Patient Enrolled _____

_____

Staff Signature / Interpretation needed? Y N date