

# Mountain Comprehensive Health Corporation REGISTRATION FORM

Today's Date:		<input type="checkbox"/> Whitesburg <input type="checkbox"/> Harlan <input type="checkbox"/> Leatherwood\Blackey <input type="checkbox"/> Owsley County <input type="checkbox"/> Buckhorn				
<b>PATIENT INFORMATION -&gt; PLEASE COMPLETE ALL INFORMATION</b>						
Last Name:		First Name:		Middle:	Previous Last Name:	Nickname:
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Social Security #: -   -		Date of Birth: /   /	
Physical Address:			City:	State:	ZIP Code:	
Mailing Address \ PO Box:			City:	State:	ZIP Code:	
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		Student Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
Home Phone: (   )		Daytime Phone: (   )		Alternate Phone: (   )		
Email Address:						
Are you employed? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Self <input type="checkbox"/> Active Duty		Are you A Coal Miner? <input type="checkbox"/> No <input type="checkbox"/> Active Coal Miner <input type="checkbox"/> Retired Coal Miner <input type="checkbox"/> Unemployed Coal Miner		Employer Name:                      Employer Phone: (   )  Employer Address:		
Primary Care Provider:			Primary Care Giver:			
<b>UDS INFORMATION</b>						
<i>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!</i>						
Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, what best describes your current situation? <input type="checkbox"/> Staying with Friends/Family <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional		If NO do you live in Public/Assisted Housing <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you a Migrant Farm Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, what describes your current situation? <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal		Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> More Than One Race						
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic		Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number in Household:		Annual Household Income: \$	
<b>RESPONSIBLE PARTY -&gt; WHO IS THE PERSON RESPONSIBLE FOR PAYING TODAY'S BILL?</b>						
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other						
Name:						
Physical Address:						
Mailing Address \ PO Box:						
Home Phone: (   )		Social Security #:    -   -		Date of Birth:    /   /		
<b>FOR OFFICE USE ONLY</b>						
Reviewed By: _____ Date: ____ / ____ / ____						

**\*\*ATTENTION CLERK: PLEASE SCAN TO PATIENT RECORD AS SOON AS POSSIBLE!\*\***

**INSURANCE → WHICH INSURANCE SHOULD BE BILLED FOR TODAY'S VISIT?**

**PRIMARY INSURANCE:**  NONE  WORKERS COMP: \_\_\_\_\_  COVENTRY  WELLCARE  MEDICARE  KY MEDICAID  HUMANA  ANTHEM  BLUEGRASS FAMILY HEALTH  OTHER: \_\_\_\_\_

**SECONDARY INSURANCE:**  NONE  WORKERS COMP: \_\_\_\_\_  COVENTRY CARES  WELLCARE  MEDICARE  KY MEDICAID  HUMANA  ANTHEM  BLUEGRASS FAMILY HEALTH  OTHER: \_\_\_\_\_

**Medicaid Insurance:**  NONE  COVENTRY CARES  WELLCARE  PPASSPORT  HUMANA  ANTHEM  KENTUCKY HEALTH COOPRATIVE  OTHER: \_\_\_\_\_

**YOU MAY QUALIFY FOR A DISCOUNT!!!**

Please review the chart below.

If your Income to Family Size Ratio falls into the first 4 columns, you may be eligible for the MCHC Sliding Scale.

To verify eligibility, please sign the appropriate box below and ask your MCHC Receptionist.

LEVEL	100% and below	101% - 125%	126% - 150%	151% - 200%	200% and above
CHARGE	\$25.00 nominal	25% of Charge or \$35 whichever is lower- per procedure (not less than \$26)	50% of Charges or \$50, whichever is lower - per procedure (not less than \$26)	75% of Charges, or \$75, whichever is lower- per procedure (not less than \$26)	100% of Charges
FAMILY SIZE	INCOME UP TO	INCOME UP TO	INCOME UP TO	INCOME UP TO	INCOME OVER
1	11,880	14,850	17,820	23,760	23,760
2	16,020	20,025	24,030	32,040	32,040
3	20,160	25,200	30,240	40,320	40,320
4	24,300	30,375	36,450	48,600	48,600
5	28,440	35,550	42,660	56,880	56,880
6	32,580	40,725	48,870	65,160	65,160
7	36,730	45,913	55,095	73,460	73,460
8	40,890	51,113	61,335	81,780	81,780
9	45,050	56,313	67,575	90,100	90,100
10	49,210	61,513	73,815	98,420	98,420

FOR FAMILY UNITS OF MORE THAN 10 MEMBERS, ADD \$4,160 FOR EACH ADDITIONAL MEMBER.

**I AM 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

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**I AM 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

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**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone #: ( )	Work Phone #: ( )
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