REVISED BY: IF 05/03/16

Mountain Comprehensive Health Corporation

REGISTRATION FORM

Today's Date:	❑ Whitesburg ❑ Harlan ❑ Leatherwood\Blackey ❑ Owsley County ❑ Buckhorn ❑ Pineville

PATIENT INFORMATION -> *PLEASE COMPLETE ALL INFORMATION*

Last Name:	First Name:	Middle:	Previous Last Name:	Nickname:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security #: - -	Date of Birth: / /	Sex: ❑ M ❑ F

Physical Address:	City:	State:	ZIP Code:
Mailing Address \ PO Box:	**City:**	**State:**	**ZIP Code:**

Language: ❑ English ❑ Spanish ❑Other	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated	Student Status: ❑ Full-Time ❑ Part-Time

Home Phone: ( )	Daytime Phone: ( )	Alternate Phone: ( )

Email Address:

Are you employed? ❑ Full Time ❑ Part Time ❑ Unemployed ❑ Retired ❑ Self ❑ Active Duty	Are you A Coal Miner? ❑ No ❑ Active Coal Miner ❑ Retired Coal Miner ❑ Unemployed Coal Miner	Employer Name: Employer Phone: ( ) Employer Address:

Primary Care Provider:	Primary Care Giver:

UDS INFORMATION

As a federally qualified health center, MCHC must attempt to obtain the information requested below. By providing the information below, you are aiding MCHC in our efforts to achieve our mission of using our resources to meet the healthcare needs of our service area through programs such as sliding scale and indigent medicine. Thank you for taking your time to provide us with this information.

Are you homeless? ❑ Yes ❑No	If YES, what best describes your current situation? ❑Staying with Friends/Family ❑ Shelter ❑ Street ❑ Transitional	If NO do you live in Public/Assisted Housing ❑ Yes ❑ No

Are you a Migrant Farm Worker? ❑ Yes ❑ No	If so, what describes your current situation? ❑ Migrant ❑ Seasonal	Do you need an Interpreter? ❑ Yes ❑ No

Race: ❑ White ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ More Than One Race

Ethnicity: ❑ Hispanic ❑ Not Hispanic	Veteran: ❑ Yes ❑ No	Number in Household:	Annual Household Income: $

RESPONSIBLE PARTY -> *WHO IS THE PERSON RESPONSIBLE FOR PAYING TODAY'S BILL?*

❑ Self ❑ Spouse ❑ Parent ❑ Other

Name:

Physical Address:

Mailing Address \ PO Box:

Home Phone: ( ) **Social Security #: - -** **Date of Birth: / /**

FOR OFFICE USE ONLY

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:_____ ❑ AETNA ❑ WELLCARE ❑ MEDICARE ❑ KY MEDICAID ❑ HUMANA ❑ ANTHEM ❑ BLUEGRASS FAMILY HEALTH ❑ OTHER:_____

SECONDARY INSURANCE: ❑ NONE ❑ WORKERS COMP:_____ ❑ AETNA ❑ WELLCARE ❑ MEDICARE ❑ KY MEDICAID ❑ HUMANA ❑ ANTHEM ❑ BLUEGRASS FAMILY HEALTH ❑ OTHER:_____

MEDICAL INSURACE: ❑ NONE ❑ AETNA ❑ WELLCARE ❑ PASSPORT ❑ HUMANA ❑ ANTHEM ❑ OTHER:_____

YOU MAY QUALIFY FOR A DISCOUNT!!!

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.

This Chart can be used for Medical and Optometry visits only.

Please contact the dental department for more information on dental sliding scale details.

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	INCOME	INCOME	INCOME	INCOME	INCOME
SIZE	UP TO	UP TO	UP TO	UP TO	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.

YES 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**

NO 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**

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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