

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 <input type="checkbox"/> Isom <input type="checkbox"/> Cumberland <input type="checkbox"/> Pineville					
PATIENT INFORMATION → PLEASE COMPLETE ALL INFORMATION							
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: / /		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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:			
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? <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: \$	
RESPONSIBLE PARTY → WHO IS THE PERSON RESPONSIBLE FOR PAYING TODAY'S BILL?							
<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: / /			
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: <input type="checkbox"/> NONE <input type="checkbox"/> WORKERS COMP: _____ <input type="checkbox"/> AETNA <input type="checkbox"/> WELLCARE <input type="checkbox"/> MEDICARE <input type="checkbox"/> KY MEDICAID <input type="checkbox"/> HUMANA <input type="checkbox"/> ANTHEM <input type="checkbox"/> BLUEGRASS FAMILY HEALTH <input type="checkbox"/> OTHER: _____					
SECONDARY INSURANCE: <input type="checkbox"/> NONE <input type="checkbox"/> WORKERS COMP: _____ <input type="checkbox"/> AETNA <input type="checkbox"/> WELLCARE <input type="checkbox"/> MEDICARE <input type="checkbox"/> KY MEDICAID <input type="checkbox"/> HUMANA <input type="checkbox"/> ANTHEM <input type="checkbox"/> BLUEGRASS FAMILY HEALTH <input type="checkbox"/> OTHER: _____					
MEDICAL INSURANCE: <input type="checkbox"/> NONE <input type="checkbox"/> AETNA <input type="checkbox"/> WELLCARE <input type="checkbox"/> PASSPORT <input type="checkbox"/> HUMANA <input type="checkbox"/> ANTHEM <input type="checkbox"/> 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, Optometry, and Behavioral Health 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	\$35	\$50	\$75	100% of Charges
FAMILY INCOME	INCOME	INCOME	INCOME	INCOME	INCOME
SIZE UP TO	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			
<i>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.</i>			
X _____ Patient Signature	_____ Date		
NO I AM NOT INTERESTED IN SLIDING SCALE			
<i>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.</i>			
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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