Patient Demographics

Date:	**Date of Birth:**	**Social Security Number:**
Patient Full Name:		
Address:		
City:	**State:**	**Zip Code:**

Home Phone:		**Cell Phone:**	**Relative Phone:**
Best time to reach you:		Day: Night:	**Email Address:**
Emergency Contact Name:			**Emergency Contact Number:**
Gender:	☐ Male	☐ Female	**Age:**

Marital Status:	☐ Married	☐ Widowed	☐ Single	☐ Separated	☐ Divorced ☐ Life Partner
Student Status:	☐ Fulltime	☐ Part-time	☐ Not a Student		**Veteran Status:** ☐ Yes ☐ No

Homeless Status:	☐ Not Homeless ☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional	
Migrant Worker Status:	☐ Migrant ☐ Not a Farm Worker ☐ Seasonal	
Language Barrier:	☐ Yes ☐ No	**Your primary spoken language:**

Race:	☐ Native American Indian ☐ Native Hawaiian ☐ White ☐ Asian ☐ Black/African American ☐ Other Pacific Islander ☐ Hispanic
Ethnicity:	☐ Hispanic/Latino ☐ Not Hispanic

Number of family members in household:	
How did you hear about CHDC?	

*******State your household income in one of the following categories listed below*******				
Household Income:	Weekly:	Biweekly:	Monthly:	Yearly:

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with Community Health and Dental Care. Although we will compile the necessary forms to file to your insurance company it is the responsibility of the patient to dispute any services not covered by the insurance company.

I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement

_____ _____

Patient/Guardian Signature **Date**

Patient Name:	**Date of Birth:**

Patient Insurance Information

Leave sections blank if they do not apply

MEDICAL INSURANCE

Primary Medical Care Provider:	
Primary Medical Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

Secondary Medical Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

DENTAL INSURANCE

Primary Dental Provider:	
Primary Dental Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

Secondary Dental Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

VISION INSURANCE

Primary Vision Provider:	
Primary Vision Insurance Coverage:	
Subscribers Name:	**Relationship to Patient**
Group Number:	**ID Number:**

Secondary Vision Insurance Coverage:	
Subscribers Name:	**Relationship to Patient:**
Group Number:	**ID Number:**

Patient Name:	**Date of Birth:**

Outreach Consultation Form

As a patient of Community Health & Dental Care, you are eligible to receive **FREE** assistance from our team of highly experienced Patient Case Coordinators. Please review the following list of services and provide your signature to acknowledge receipt. If you would like to consult with one of our Case Coordinators, please indicate below:

Families

- ☐ Medicaid
- ☐ CHDC Pharmacy Services
- ☐ Chip
- ☐ CHDC Health Care Discount Application (Sliding Fee)
- ☐ Enrollment Services (Choosing an HMO and CHDC as PCP)
- ☐ CCIS (Child Care Information Service, subsidized child care)
- ☐ SNAP (Supplemental Nutritional Assistance Program)
- ☐ Cash Assistance
- ☐ School Meals (Assistance)
- ☐ LIHEAP (Low Income Heating Assistance Program)
- ☐ Healthy Women (Free mammograms, clinical breast and pelvic exams, and PAP tests)
- ☐ Marketplace
- ☐ Referrals to Mental Health and Substance Abuse Treatment Options
- ☐ Literacy Council of Montgomery County, Chester County, and Berks County
- ☐ Legal Aid
- ☐ WIC (Women Infant Children)
- ☐ Laurel House (Domestic Violence)
- ☐ Safe Haven (Adoptive Service)
- ☐ CADCOM (Assistance with Utility Services)
- ☐ Housing Referrals
- ☐ CHDC Patient Transportation Assistance Program (Free transportation for our patients)
- ☐ TransNet, Barta, Rover (Medical assistance Transportation Program
- ☐ PAP (Patient pharmaceutical assistance program)
- ☐ "New Eyes" (free eyewear: frames and lenses)

Adults

- ☐ Aging and Adult referrals
- ☐ Medicare Advantage Plans
- ☐ Medicare Part D (Prescription Drug Coverage)
- ☐ Support Services Waiver Referrals
- ☐ AIDS Waiver Program
- ☐ Pace
- ☐ Pace-Net

Would you like to schedule an appointment with a Patient Case Coordinator? **Y / N**

Patient Signature:

Patient Name:	**Date of Birth:**

Healthcare Discount Information

What is a Health Care Discount?

The health care discount is a program for offering most CHDC services at a lower cost to families who meet certain financial requirements, based on the federal poverty income guidelines. The health care discount application is based on family size and gross income. Patients pay for services according to the discount they qualify for.

Who Can Apply?

All patients are required to complete a health care discount application.

Patients with insurance can also apply for the health care discount. CHDC will submit your bill to your insurance company at the full fee. If the insurance bill is rejected, applied to the deductible, or paid in part; your balance will be reviewed for possible discounts.

How Do I Apply?

Request the health care discount application from any CHDC staff or from our website at www.ch-dc.org. Click on "for the patients" tab, and then financial assistance, this will take you to the applications.

What Type of Income Verification or Documents Will I Need?

All patients must submit **TWO** current paystubs, and a copy of your current tax return (1040), SNAP, Medicare SSI Award Letter, or any other legal document verifying your income.

In addition, if you are receiving Social Security, Disability, or Pension Benefits, you will be required to submit a statement from these agencies verifying the amount of benefit being received.

Proof of income must be received within 30-days of signing the health care discount application, or by your next visit. If all the required proof has not been received, no further discounts will be honored. You will be responsible to pay 100% of charges until all required information has been received by the Patient Financial Department.

How Long is my Application Good For?

The approved health care discount application is valid for 12 months from the processed date. At any time if you have a change in income status, you must reapply for the discount.

What Services WILL BE Discounted if I am Approved for the Health Care Discount?

1. Office Visits
2. Most Medical/Vision Procedure
3. Any lab tests completed and processed at CHDC
4. Most Dental procedures completed in our office
5. Dispensary

Services That May Not Be Fully Discounted:

1. Any dental procedures that have a lab fee, as discussed with dental personnel
2. Vaccines that purchased by CHDC
3. There will be certain labs that are drawn and sent to outside labs for additional testing which will be the responsibility of the patient
4. Quest and Lab Corp offer their own discounts

Questions?

Please see any member of the front desk or the Patient Financial Department. They will be happy to assist you with any questions or concerns.

Patient Name:	**Date of Birth:**

Healthcare Discount Application

Please fill out the application completely and attach all income information.

HOUSEHOLD INFORMATION - List household members claimed on tax form (1040, 1040A and/or 1040EZ) and/or other forms

Name (Including Yourself)	**Social Security Number:**	**Date of Birth:**	**Relationship:**

I have completed this application for healthcare discount eligibility and confirm that all my information is correct to the best of my knowledge. I understand a minimum payment of $20.00 for Medical/Vision/BH, $35.00 for Dental Services and $5.00 for Pharmacy will be collected at the time of each visit. I understand that discounts are available regardless of my insurance status and if I do not qualify for a discount, I will be responsible to pay 100% of billed charges. For example, if I am eligible for an 80% discount I will be responsible for 20% of the applicable charges. I am aware that this discount does not apply to Dental and Medical lab fees. I understand for self-declared individuals that my slide discount may change subject to administrative approval.

☐ Community Health and Dental Care has offered and explained to me the benefits of applying for the healthcare discount. At this time I choose not to apply for the healthcare discount. I understand that I may apply at any time should I change my mind or my personal situation changes such as household size, insurance status and/or gross income.

Applicants Signature:	**Date:**

DO NOT FILL OUT BELOW THIS LINE – ELIGIBILITY INFORMATION – FOR OFFICE USE ONLY

PROOF OF INCOME

☐ Most recent Income Tax Returns (1040, 1040A, 1040EZ; applicable adjusted gross income line)			
☐ Two recent pay stubs (Check one)	☐ Weekly	☐ Biweekly	☐ Monthly
☐ Social Security / Disability Letters			
☐ Proof of Residency			
☐ Other:			

Annual Gross Income $:	Family Size:
Patient Discount Applied to Applicable Charges:	
Medical/Vision Discount:	☐ 100% ☐ 80% ☐ 60% ☐ 40% ☐ 20% ☐ 0%
Dental Discount:	☐ 100% ☐ 70% ☐ 55% ☐ 40% ☐ 25% ☐ 0%
Pharmacy Discount:	☐ 100% ☐ 80% ☐ 60% ☐ 40% ☐ 20% ☐ 0%

Processed By:	**Date:**

Patient Name:	**Date of Birth:**

Self-Declaration of Income and Housing Form

☐ I do not get paid in cash
☐ I do not get paid in checks
☐ I do not get pay stubs
☐ Estimate, No Documentation Provided
☐ I cannot get a letter from my employer
Explain Why:
My Income is $
How Often (Weekly, Bi-Weekly, Monthly):
Current Employer or the type of work I do is:
Complete the information below only if you have no other way to document your housing.
I, _____certify that I am currently residing at the following address: _____
My average monthly housing cost is $ _____. If needed, you may contact the following person to verify this information.

Name:	**Telephone:**
Address:	

I certify that I have no other way to document my income and/or housing and that all of the above information is true and correct. I understand that this information is used to determine eligibility for the Healthcare Sliding Fee Discount Program. I understand that the program officials may verify information provided on this form. I also understand that if I intentionally misrepresent my income, I may have to repay the benefits received. I understand that this application may be subject to change after final administrative approval.

Signature: _____ **Date:** _____ **Slide Amount Approved:** _____
(Patient)

Signature: _____ **Date:** _____
(CHDC Staff Person)

Signature: _____ **Date:** _____
(CEO)

Patient Name:	**Date of Birth:**

Healthcare Discount Application

Self-Employment Form

Name:	**Date:**

To Whom it may concern:

I, _____ the undersigned residing at _____

_____ certify that I am self-employed at the following jobs:

1.
2.
3.

I attest that (based upon the attached documentation, i.e. receipts for services rendered, income tax returns, etc.)

the following is the approximate amount of income that I receive monthly $ _____,

or annually $ _____.

_____ _____

Signature Date

_____

Print Name

Patient Name:	**Date of Birth:**