St. Jude Neighborhood Health Centers

St. Jude Neighborhood Health Centers
La Amistad Health Center
St. Mary Health Centers
Puente A La Salud

Patient Registration

MRN:

Thank you for choosing us as your healthcare provider. Our Mission, in the tradition of the Sisters of St. Joseph of Orange, is to improve the health and well-being…of people in the communities we serve. For efficient registration, please complete all questions on this form.

Last Name: **First Name:** **Middle Name:**	
Social Security #: - -	**Date of Birth:**
Gender: □ Female □ Transgender Female – male to female □ Male □ Transgender Male – female to male □ Other □ Gender Queer	**Preferred Language:** □ English □ Spanish □ Other: _____
Marital Status: □ Single □ Married □ Widow/er □ Separated □ Divorced	**Race (choose all that apply):** □ Asian □ Native Hawaiian □ Other Pacific Islander □ Black/African American □ American Indian/Alaska Native □ White
Ethnicity: □ Hispanic/Latino □ Non-Hispanic/ Non-Latino	

Street Address:		
City:	**State:**	**Zip Code:**
Phone Numbers Mobile: Home: Work: **Preferred Contact Number:** □ Mobile □ Home □ Work		
Email Address:		□ **Yes, register me for the patient portal**

Employment Status: □ Disabled □ Employed Full-Time □ Employed Part-Time □ Student Full-Time □ Not Employed □ Active Duty Military □ Retired □ Self-Employed	**Emergency Contact Person:** Name: _____ Relationship: _____ Phone #:_____ Address: _____ City: _____ State_____ Zip Code: _____

St. Jude Neighborhood Health Centers receives grants that support our work; the grants require that we ask you the following questions:

How many people are in your family/household:
What is your family/household <u>monthly</u> income:
Does anyone in your family/household work as a migratory or seasonal farmworker? □ **Yes** □ **No** (individuals working in landscaping or at a dairy are not considered farmworkers)
Sexual Orientation: □ Bisexual □ Choose Not to Disclose □ Don't know □ Lesbian, gay, homosexual □ Something else □ Straight, Heterosexual
Are you currently (as of last night) homeless? □ **Yes** □ **No** (if you stayed in a shelter, transitional housing, on a friend's sofa, or on the street because you don't have a home, you should answer 'yes').
Do you reside in public housing? □ **Yes** □ **No** (The Section 8 Voucher program is not considered Public Housing – answer 'no' if you use Section 8 Vouchers)
Are you a veteran of United Sates Uniformed Services? □ **Yes** □ **No**
How did you learn about our clinic?
Do you want information on Advance Directives? □ **Yes** □ **No** An Advanced Directive is a document describing your wishes regarding medical treatment, often including a living will, that is used if/when you cannot communicate your wishes to a doctor as a result of an injury or illness.
Do you have health Insurance? □ **No –** To be considered for our discounted fee program, <u>you must complete all of the Financial Screening questions on the attached pages</u>. You must also <u>provide all required supporting documents</u>. □ **Yes**, my insurance is: _____.

Please sign and date this form and then turn it into our receptionist.

The above information is true to the best of my knowledge. I request and authorize St. Jude Neighborhood Health Centers to provide me with health care services. I understand that St. Jude Neighborhood Health Centers may use and disclose my information as described in the Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices. I have reviewed and agree to comply with the St. Jude Neighborhood Health Center patient contract (red form). I acknowledge St. Jude Neighborhood Health Centers receives HHS funding and has Federal Public Health Service deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and for its covered individuals. I understand that I will never be denied care due to an inability to pay and that I can apply for discounted fees based on my income.

I understand and agree to notify St. Jude Neighborhood Health Centers if any of the information on this form should change while I am under their care. I understand that I may qualify for reduced fees based on my household income.

_____ _____

Signature **Date**

FO Rep: _____ Date Reviewed and Entered: _____

Complete this form if you do NOT have health insurance

Financial Assistance Application

Date Received:

Last Name:	**First Name:**	MRN:
Address:		New Patient □Yes □No

Income Sources	Amounts
Salary & Wage (before deductions)	
Self-Employment Income	
Interest & Dividends	
Real Estate Income	
Social Security Benefits	
Alimony / Child Support	
Unemployment / Disability	
Other	
Total	**$**

Answer the questions for each family member – (use N/A if it does not apply):

First Name:	**Last Name:**	**Wants to be considered for the reduced fee program? □ Yes □ No** **New patient? □ Yes □ No**
Date of Birth:	**Age:**	**Social Security Number:**
Relationship to you:	**Monthly Income:**	**Income Source/Employer:**

First Name:	**Last Name:**	**Wants to be considered for the reduced fee program? □ Yes □ No** **New patient? □ Yes □ No**
Date of Birth:	**Age:**	**Social Security Number:**
Relationship to you:	**Monthly Income:**	**Income Source/Employer:**

First Name:	**Last Name:**	**Wants to be considered for the reduced fee program? □ Yes □ No** **New patient? □ Yes □ No**
Date of Birth:	**Age:**	**Social Security Number:**

Relationship to you:	Monthly Income:	Income Source/Employer:

First Name:	Last Name:	Wants to be considered for the reduced fee program? □ Yes □ No New patient? □ Yes □ No
Date of Birth:	Age:	Social Security Number:
Relationship to you:	Monthly Income:	Income Source/Employer:

First Name:	Last Name:	Wants to be considered for the reduced fee program? □ Yes □ No New patient? □ Yes □ No
Date of Birth:	Age:	Social Security Number:
Relationship to you:	Monthly Income:	Income Source/Employer:

Assets (please estimate value and debt):

Asset	Value	Debt (amount owed)
House (primary residence)		
Other real estate		
Motor vehicles		
Bank Account & Investments		
Retirement plans		
Other		
Total:		

Do you have any unusual, large expenses, such as medical bills, bankruptcy settlements or court judgments? If yes, please explain the expense and list amount per month that you are required to pay:

To qualify for discounts on your fees, you must attach the following:

- □ Tax Return for most recent year (must include W2s) for everyone in household
- □ Copies of information on any health insurance coverage anyone in the house might have
- □ Proof of address (Government ID or bill mailed to your home address)

If you don't have a tax return:

- □ Two recent paystubs (include any SSI, alimony, or child support payments) for anyone receiving income in the household
- □ Two recent bank statements for everyone in the household with a bank account

I attest that the above information is true to the best of my knowledge. I understand that I must notify St. Jude Neighborhood Health Centers if my insurance status or income changes.

_____ _____

Signature **Date**

Rep: _____ Date Reviewed: _____

SJNHC 042020