

## PATIENT INFORMATION

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Previous Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Sex:  Male  Female

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status:  Single  Married  Widowed  Divorced  Separated  Other

Street Address: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

If patient is a minor, give parent's or guardian's name: \_\_\_\_\_ Minor lives with: \_\_\_\_\_

Pharmacy Name & Phone #: \_\_\_\_\_

## EMERGENCY INFO

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Address: \_\_\_\_\_ City, State: \_\_\_\_\_

Home: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

### Race

#### Asian:

Asian Indian  Chinese  Filipino  
 Japanese  Korean  Vietnamese  
 Other Asian

#### Native Hawaiian/Other Pacific Islander:

Native Hawaiian  Other Pacific Islander  
 Guamanian or Chamorro  
 Samoan  
 Black/African American  
 American Indian  White  
 Decline to Answer

### Ethnicity

#### Hispanic or Latino/a or Spanish:

Mexican, Mexican American, Chicano/a

Puerto Rican  Cuban

Another Hispanic, Latino/a or Spanish

#### Origin

More than one ethnicity

Non-Hispanic or Latino/a

Decline to Answer

### Preferred Language

English

Spanish

American Sign  
Language

Other: \_\_\_\_\_

### Pronouns

she/her

he/him

they/them

other: \_\_\_\_\_

### Sexual Orientation

Lesbian, gay or homosexual

Straight or heterosexual

Bisexual

Don't know

Choose not to disclose

### Gender Identity

Male  Female

Female-to-male (FTM)/Transgender  
Male/Trans Man

Male-to-Female (MTF)/Transgender  
Female/Trans Women

Genderqueer, neither exclusively male  
nor female

Choose not to disclose

## Please Circle Your Answer Below:

1. Are you a U.S. Veteran? **YES or NO**

2. Are you or anyone in your family in the past 2 years been considered a Seasonal Farmworker? (A person whose source of income is earned mostly in agricultural work, without moving away from home) **YES or NO**

3. Are you or anyone in your family in the past 2 years been considered a Migrant Farmworker? (A person who has moved away from home and established a temporary home in order to work primarily in agriculture) **YES or NO**

**DENTAL INSURANCE INFORMATION**

See Card

Insurance Policy Name: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_ Group Name: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

See Card

Primary Insurance Name: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Group #: \_\_\_\_\_

**PARTY RESPONSIBLE FOR PATIENT BILL (IF DIFFERENT THAN PATIENT)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Best Contact Phone Number: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

**CONSENT TO RECEIVE VOICEMAIL, TEXT AND/OR EMAIL MESSAGES**

Patients in our practice may be contacted via voicemail, email and/or text messaging as a reminder of appointment(s), and/or to provide healthcare reminders/information. By initialing, I consent to receiving appointment reminders, patient portal information, and other healthcare communications and/or information from High Country Community Health. I understand that this consent will apply to all future communication unless I request a change in writing. **Initial** \_\_\_\_\_

I authorize to receive voice and/or text messages to the phone numbers provided below. I authorize to receive email messages at the email provided below.

Home Phone: \_\_\_\_\_  Brief message (includes no health information)  Extended message (Detailed)

Cell Phone: \_\_\_\_\_  Brief message (includes no health information)  Extended message (Detailed)

Email Address: \_\_\_\_\_  Brief message (includes no health information)  Extended message (Detailed)

**Revoke or Decline Use Only:** I hereby decline my consent to receive any future appointment reminders, patient portal information, and/or healthcare information via  voicemail  text messaging and/or  email.

I GIVE HIGH COUNTRY COMMUNITY HEALTH PERMISSION TO SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PEOPLE IF REQUESTED:

Name: \_\_\_\_\_ Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Consent for Healthcare and Release of Personal Health Information:**

I voluntarily consent to healthcare treatment (i.e., Dental, Medical Care, and/or Behavioral Health) from the providers and staff of High Country Community Health (HCCH). I consent to all necessary treatment of illness and injuries and preventative care including screenings, lab work, (including HIV testing), immunizations, and referrals. I am aware that neither the practice of medicine, dental treatment, nor the delivery of mental/behavioral health treatment is an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that HCCH employs a “team based” approach to the delivery of healthcare and that health information may be exchanged between HCCH providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about me for treatment, payment, and healthcare operations. I understand that my medical information could include medical history or information regarding diagnosis and treatment for communicable disease (such as sexually transmitted infection, HIV/AIDS or hepatitis), mental illness, alcohol or substance use. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Title’s V, XVIII, and/or XIX of the Social Security Act is correct. I certify that I have read and understand this form. I understand that I am automatically enrolled in the Health Information Exchange, but at any time can opt-out by visiting [www.highcountrycommunityhealth.com](http://www.highcountrycommunityhealth.com) and completing the Opt-out form. I understand that North Carolina Statutes Section 90-21.5 protects a minor’s rights to receive services relating to sexually transmitted disease, pregnancy, drug abuse and emotionally disturbances without parental consent. I understand that according to NC General Statutes 90-21.4 medical providers are not required to notify me about services provided in these areas unless the situation indicates that notification is essential to the life or health of the minor. I understand that if I request information about these services, the medical provider will share information with me only if the provider considers it in the best interest of my child’s health and welfare to do so. This consent is renewable annually. I may withdraw authorization for services at any time. Initial \_\_\_\_\_

**HIPAA Notice of Privacy Practice Acknowledgement:**

We are required, upon request, by law to provide you with our HIPAA Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you as follows: by visiting [www.highcountrycommunityhealth.com](http://www.highcountrycommunityhealth.com), or by requesting one at any HCCH location. Initial \_\_\_\_\_

**Financial Responsibility and Assignment of Insurance Benefits:**

I understand that for my convenience HCCH accepts Cash, Checks (no starter checks), Visa, MasterCard, Discover or Care Credit (dental only). I also understand that HCCH files with Medicaid, Medicare and many private insurance companies. I authorize my insurance benefits to be paid to HCCH. It is my responsibility to check that HCCH is in network with my private/dental insurance prior to my first appointment. Co-pays are due and collected at the time the services are rendered. If for any reason my insurance company does not pay its estimated portion the balance will be my responsibility. I agree to promptly pay for any balance not covered by insurance. I understand that there may be additional charges including, but not limited to, health screening, behavioral health services, nutritional services, dental services, vaccines and injections. Labs sent to outside laboratories (e.g., LabCorp, Wake Forest Labs or Quest) will be billed separately and are not a part of HCCH. A separate bill from the lab company will arrive by mail. A copy of my Driver’s License/Photo ID is required for every patient along with a copy of your Medical/Dental Insurance Card or Medicaid Card. High Country Community Health also provides a Sliding Fee Scale payment option for all our patient. Proof of income and household size are required to qualify. Initial \_\_\_\_\_

I understand that if I am 18 years of age or older, I may consent for health services; otherwise my parent or legal guardian will need to consent for services.

\_\_\_\_\_  
Signature of Patient or Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insured Party of Financial Guarantor (if different from above)

\_\_\_\_\_  
Date

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Patient Health Screenings for Depression and Anxiety (PHQ-9 and GAD-7):**

Your health and wellness are our goals at High Country Community Health. In order to provide you with the best possible care, it is important that we have all information about your physical and mental health as well as your lifestyle habits. Whole person care means not only that the mind and body are connected, but that they affect all aspects of your health. Please complete the Patient Health Screenings below so that your medical provider is better able to help you reach and maintain your best level of health.

*Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.*

<b>PHQ-9</b>	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
<i>Add the score for each column</i>				

*Total Score (add your column scores):* \_\_\_\_\_

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

*Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.*

<b>GAD-7</b>	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>				

*Total Score (add your column scores):* \_\_\_\_\_

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

**AUDIT**

*In reference to the last 12 months, please circle your response.*

1. **How often do you have a drink containing alcohol?**  
 (0) Never      (1) Monthly      (2) 2-4 times a month      (3) 2-3 times a week      (4) 4 or more times a week
  2. **How many drinks containing alcohol do you have on a typical day when you are drinking?**  
 (0) 1-2      (1) 3-4      (2) 5-6      (3) 7-9      (4) 10 or more
  3. **How often do you have six or more drinks on one occasion?**  
 (0) Never      (1) Less than monthly      (2) Monthly      (3) Weekly      (4) Daily or almost daily
  4. **How often during the last year have you found that you were unable to stop drinking once you started?**  
 (0) Never      (1) Less than monthly      (2) Monthly      (3) Weekly      (4) Daily or almost daily
  5. **How often during the last year have you failed to do what was normally expected of you because of drinking?**  
 (0) Never      (1) Less than monthly      (2) Monthly      (3) Weekly      (4) Daily or almost daily
  6. **How often during the last year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?**  
 (0) Never      (1) Less than monthly      (2) Monthly      (3) Weekly      (4) Daily or almost daily
  7. **How often during the last year have you felt guilt or remorse after drinking?**  
 (0) Never      (1) Less than monthly      (2) Monthly      (3) Weekly      (4) Daily or almost daily
  8. **How often during the last year have you been unable to remember what happened the night before because of drinking?**  
 (0) Never      (1) Less than monthly      (2) Monthly      (3) Weekly      (4) Daily or almost daily
  9. **Have you or someone else been injured as the result of your drinking?**  
 (0) No      (2) Yes, but not in the last year      (4) Yes, during the last year
  10. **Has a friend, relative, doctor or other health worker been concerned about your drinking or suggested you cut down?**  
 (0) No      (2) Yes, but not in the last year      (4) Yes, during the last year
- Total Score (add your circled responses):** \_\_\_\_\_

**DAST-10**

*In reference to the last 12 months, please circle your response.*

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you always able to stop using drugs when you want to?
4. Have you had "blackouts" or "flashbacks" as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medial problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?

1.Yes	No
2.Yes	No
3.Yes	No
4.Yes	No
5.Yes	No
6.Yes	No
7.Yes	No
8.Yes	No
9.Yes	No
10.Yes	No

**Total Score (add your circled YES responses):** \_\_\_\_\_

## ADULT MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**PLEASE LIST YOUR OTHER HEALTH CARE PROVIDERS: If you need more space, write on the back of this form.**

Specialty	Doctor's Name	Date of last visit
Primary Care Provider (PCP)		
Eye Doctor		
Dentist		
Other:		

**MEDICATIONS: Please list all medications you are currently taking including birth control, vitamins, supplements, and over the counter medications. If you need more space, write on the back of this form. \*Please bring all medications bottles to each appointment\***

Drug	Dosage	Frequency

**MEDICAL/DENTAL HISTORY: Please check all current AND previous illnesses/conditions for your medical and/or dental history.**

<input type="checkbox"/> Blood Disease <input type="checkbox"/> Breast Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes/Thyroid Problems <input type="checkbox"/> Female Problems <input type="checkbox"/> Head, Eyes, Ear, Nose, Throat <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Learning Disability <input type="checkbox"/> Lung Problems (COPD, Asthma) <input type="checkbox"/> Male Problems <input type="checkbox"/> Mental Illness <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Rheumatology/Arthritis	<input type="checkbox"/> Skin Problems <input type="checkbox"/> Stroke/Seizures <input type="checkbox"/> Stomach Problems <input type="checkbox"/> STI/STD <input type="checkbox"/> Vision Problems <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Bad Breath <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Clicking/Popping Jaw <input type="checkbox"/> Grinding Teeth <input type="checkbox"/> Loose Teeth/Broken Fillings <input type="checkbox"/> Periodontal Treatment <input type="checkbox"/> Sensitivity to cold, hot, sweets <input type="checkbox"/> Sensitivity when biting <input type="checkbox"/> Sores or growth in your mouth <input type="checkbox"/> Other: _____
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**ALLERGIES: Please list any food or drugs that you are allergic to. If you need more space, write on the back of this form.**

Food or Drug	Reaction	Mild/Moderate/Severe

**GYN/OB History Women Only:**

Is there a possibility of pregnancy? **YES or NO** Expected delivery date: \_\_\_\_\_ Are you nursing? **YES or NO**

Are you taking Birth Control pills (Antibiotics may alter the effectiveness)? **YES or NO**

Date of last period: \_\_\_\_\_ Age when period started: \_\_\_\_\_ Age when period stopped (Menopause): \_\_\_\_\_

Date of last Pap Test: \_\_\_\_\_ Result of last Pap Test: **NORMAL or ABNORMAL** Treatment: \_\_\_\_\_

Date of last Mammogram: \_\_\_\_\_ Result of last Mammogram: **NORMAL or ABNORMAL** Treatment: \_\_\_\_\_

# of Pregnancies: \_\_\_\_\_ #of Miscarriages: \_\_\_\_\_ # of Abortions: \_\_\_\_\_ # of Living Children: \_\_\_\_\_

1)Has a physician (Medical Doctor) recommended taking antibiotics prior to every dental visit (premed)? YES or NO

2)Have you ever taken Bisphosphonates Fosamax? YES or NO

3)Do you use controlled substances (example Percocet, Hydrocodone, Tramadol)? YES or NO

Initials: \_\_\_\_\_ DOB: \_\_\_\_\_

**PAST OPERATIONS (in the last 2 years) or HOSPITALIZATIONS (in the last 6 months):**

Type of surgery/reason for hospitalization	Name of Doctor or facility	Date

**FAMILY HISTORY: Please check family members with past/present medical history.**

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children	Non-Contributory
Bleeding Problems							
Bone Disease							
Cancer							
Diabetes/Thyroid Problems							
Glaucoma							
High Blood Pressure							
Kidney Problems							
Mental Illness/Depression							
Osteoporosis							
Stroke/Seizures							
Substance Abuse/Addiction							

**SOCIAL HISTORY: Please check any health habits.**

Activity	How often?	How much?	Type?
Tobacco			
Alcohol			
Physical Activity			
Caffeine			
Substance Use			

**REVIEW OF SYSTEMS (ROS): Please check any symptoms you currently have.**

<input type="radio"/> NONE <input type="radio"/> Fever/Chills <input type="radio"/> Fatigue <input type="radio"/> Headache <input type="radio"/> Sore throat <input type="radio"/> Sinus pain <input type="radio"/> Cough <input type="radio"/> Shortness of breath <input type="radio"/> Jaw pain	<input type="radio"/> Chest pain <input type="radio"/> Palpitations <input type="radio"/> Abdominal pain <input type="radio"/> Diarrhea <input type="radio"/> Nausea/Vomiting <input type="radio"/> Rectal bleeding <input type="radio"/> Rapid weight loss/gain <input type="radio"/> Difficulty urinating <input type="radio"/> Burning with urination	<input type="radio"/> Back/neck pain <input type="radio"/> Swelling of face/hands/feet <input type="radio"/> Joint pain <input type="radio"/> Anxiety/Depression <input type="radio"/> Suicidal thoughts <input type="radio"/> Other: _____ <input type="radio"/> Other: _____ <input type="radio"/> Other: _____
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**DATE OF MOST RECENT VACCINES:**

Flu: \_\_\_\_\_ Tetanus: \_\_\_\_\_ Pneumonia: \_\_\_\_\_ Shingles: \_\_\_\_\_ COVID-19: \_\_\_\_\_ Other: \_\_\_\_\_

**PREVENTATIVE MEDICINE: Please check and update any of the following that apply.**

	Date (Mo/Yr)	Normal Result	Abnormal Result	Where Completed?
Colonoscopy/Colorectal Cancer Screening				
Prostate Cancer Screening				
Bone Density				
HIV Screening				
Hep C Screening				

# PRAPARE FORM

## Money & Resources

What is your current housing situation?

- I have housing.
- I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, or in a park).
- I choose not to answer this question

Are you worried about losing your housing?

- Yes
- No
- I choose not to answer this question.

What is the highest level of school that you have finished?

- Less than a high school degree
- High school diploma or GED
- More than high school
- I choose not to answer this question.

What is your current work situation?

- Unemployed and seeking work
- Part-time or temporary work
- Full-time work
- I choose not to answer this question.
- Otherwise unemployed, but not seeking work (ex. Student, retired, disabled, unpaid primary care giver)

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

- Food
- Clothing
- Utilities
- I do not have problems meeting my needs
- Child care
- Medicine or any health care (medical, dental, mental or vision)
- I choose not to answer this question.
- Phone
- Other (please write in notes)

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- Yes, it has kept me from medical appointments or from getting my medications.
- Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living.
- No
- I choose not to answer this question.

## Social & Emotional Health

How often do you see or talk to people that you care about and feel close to? (For example: talking to friend on the phone, visiting friends or family, going to church or club meetings)

- Less than once a week
- 1 or 2 times a week
- 3 to 5 times a week
- More than 5 times a week
- I choose not to answer this question.

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled.

- Not at all
- Quite a bit
- Very much
- A little bit
- I choose not to answer this question.
- Somewhat

## Additional Questions

In the past year have you spent more than 2 nights in a row in jail, prison, detention center, or juvenile correctional facility?

- Yes
- No
- I choose not to answer this question.

Are you a refugee?

- Yes
- No
- I choose not to answer this question.

What country are you from?

- United States
- Country Other than the United States (please write in notes)
- I choose not to answer this question.

Do you feel physically and emotionally safe where you currently live?

- Yes
- No
- Unsure
- I choose not to answer this question.

In the past year, have you been afraid of your partner or ex-partner?

- Yes
- No
- Unsure
- I have not had a partner in the past year.
- I choose not to answer this question.

Questions that will help the Patient Resource Specialist (PRS) care team to assist you with additional needs. If your answer is yes to the below statements, please check the applicable box.

- I would like to register to vote.
- I need help filling my taxes.
- I need information about end of life decisions.
- If I were admitted to the hospital, I would need help alerting a family member about pets/issues to take care of at home.
- I/my family need a winter jacket.





## Application for Sliding Fee Scale

An application for each household is required every 12 months.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Please include all of the following sources of income for the last 12 months for each household member. (Household members who currently live together and share income and expenses.)

- |                   |                        |                        |
|-------------------|------------------------|------------------------|
| All Employment    | Alimony Payments       | Unemployment           |
| SSI Disability    | Retirement Income      | Child Support Payments |
| Work First (TANF) | Social Security Income | Any other Income       |

**Veteran Benefit**

Name	Date Of Birth	Relationship To Patient	Income Source	Gross Income Before Taxes	Frequency Paid	Front Desk Calculated Annual Amount	Front Desk Source of Verification

I certify that the income information given to High Country community Health from me is correct and accurate.

Please initial the following:

\_\_\_\_\_ Sliding Fee Scale eligibility is effective for all services provided today until 12 months from today. I understand I will need to reapply for the sliding fee scale 12 months from today.

\_\_\_\_\_ I agree to notify High Country Community Health immediately if my contact or income information changes.

***High Country Community Health will not refuse care based on inability to pay.***

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>STAFF USE ONLY</b>					
	Household Size:	Annual Gross Income:			
Verified Income:	0 – 100% FPL	101 – 125% FPL	126 – 150% FPL	151 – 200% FPL	>201% FPL

\*\*Staff: Please include income calculations in the margin of this form or on separate sheet of paper and scan it into the patients records with all income verification. \*\*



**Household Income (If completing SFS Application you may skip)**

In order for our clinic to receive federal financial support for patients of low income, we ask that you complete the following annual **household** income form. No individual information is provided to the federal government.

Based on your family size, please circle the income level of your household. The dollar amounts are maximums. For example, if you have a family size of two and make \$21,151 annually (i.e., one dollar more than the first column amount), then round up and circle \$26,438. Please ask our staff for assistance if needed.

Family Size:	Annual Household income:				
1	\$15,650	\$19,563	\$23,475	\$31,300	>\$31,300
2	\$21,150	\$26,438	\$31,725	\$42,300	>\$42,300
3	\$26,650	\$33,313	\$39,975	\$53,300	>\$53,300
4	\$32,150	\$40,188	\$48,225	\$64,300	>\$64,300
5	\$37,650	\$47,063	\$56,475	\$75,300	>\$75,300
6	\$43,150	\$53,938	\$64,725	\$86,300	>\$86,300
7	\$48,650	\$60,813	\$72,975	\$97,300	>\$97,300
8	\$54,150	\$67,688	\$81,225	\$108,300	>\$108,300

**For each additional household member, add \$5,500.**

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_