"Healing with Heart"
Elica Health Centers

PATIENT REGISTRATION

Today's Date (month/day/year)	**Preferred Name**	
First Name	**Last Name**	
Social Security Number	**Date of Birth** (month/day/year)	
Home Address		
City	**State**	**Zip Code**
Phone Number	**Alternate Phone Number**	
Email Address		

Legal Sex ☐ Female ☐ Male ☐ Nonbinary ☐ Unknown ☐ X

Gender Identity
☐ Female ☐ Male
☐ Transgender Male/Trans Man/FTM ☐ Transgender Female/Trans Woman/MTF
☐ Non-Binary/Genderqueer ☐ Questioning ☐ Two Spirit
☐ Other ☐ Choose not to disclose

Sexual Orientation
☐ Straight or Heterosexual
☐ Lesbian
☐ Gay
☐ Bisexual
☐ Asexual
☐ Omnisexual
☐ Pansexual
☐ Queer
☐ Something Else
☐ Don't Know
☐ Choose Not to Disclose / Decline

Patient's Sex Assigned at Birth ☐ Female ☐ Male ☐ Intersex ☐ Unknown ☐ Not Recorded on Birth Certificate ☐ Choose Not to Disclose

Marital Status ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

What is your ethnicity?
☐ Not Hispanic, Latino/a or Spanish Origin ☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban
☐ Other Hispanic, Latino/a or Spanish Origin ☐ Unreported / Choose Not to Disclose Ethnicity

What is your race or biological family background? (Check all that apply)
☐ American Indian ☐ Alaska Native ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro
☐ Samoan ☐ White ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Other Race
☐ Unknown ☐ Unreported / Choose Not to Disclose

Emergency Contact

Name	
Phone Number	**Relationship to Patient**

Patient Contacts

Spouse, Mother, Father, Caregiver or Guardian info:

Name_____ **DOB** _____ **Relationship to Patient** _____
Address _____ **City** _____**State** _____ **ZIP Code** _____
Phone Number _____ **Release Medical Information** ☐ Yes ☐ No

Are you experiencing homelessness?
☐ Yes ☐ No (Not Homeless) ☐ Currently Not Homeless (was in the last 12 months)

If Yes, please choose one (1) below
☐ Living in Shelter (Homeless Shelter) ☐ Transitional Housing ☐ Living with Others (Doubling Up) ☐ Street, Camp, Bridge
☐ Homeless Unknown Shelter ☐ Permanent Supportive Housing ☐ Single Occupancy Hotel (Other) ☐ At Risk for Homelessness
☐ At Risk for Homelessness (Child) ☐ At Risk for Homelessness (Veteran)

Are you a migrant / seasonal worker? ☐ Migrant ☐ Seasonal ☐ Neither

Employment

Employment Status ☐ Full time ☐ Part time ☐ Unemployed

Do you need an interpreter? ☐ Yes ☐ No	**Do you speak English?** ☐ Yes ☐ No, My preferred language is _____
English Fluency ☐ Excellent ☐ Very Good ☐ Good ☐ Not Good ☐ Not at All	
Preferred Written Language	**Preferred Language Spoken**

Would you like assistance during your appointment?

☐ Yes, support for Low Vision or Blindness.
☐ Yes, Hard of hearing.
☐ Yes, Mobility Assistance (please describe)_____
☐ Yes, other (please describe) _____

Veteran/Military Status ☐ Yes ☐ No, I am not a veteran (or served in the military)

Additional Demographics

Country of Origin _____
ID/Driver License _____ **State** _____ **Expiration Date** _____

Insurance Guarantor

☐ Self
☐ For children - name of parent or legal guardian _____ Day of Birth (month/day/year) _____
Address *(if different from patient's)* _____ **City** _____ **State** ____ **ZIP Code** _____
Relationship to Patient _____

Total number of people in your household (you and your dependents) _____
What is your household income before taxes $ _____ ☐ Monthly ☐ Yearly ☐ Choose Not to Disclose

What pronouns do you use?

☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Ze/Hir/Hirs ☐ Ey/Em/Eirs ☐ Xe/Xem/Xyrs ☐ Ve/Vir/Virs
☐ Other ☐ Patient's Name ☐ Unknown ☐ Decline to Answer

How do you want us to contact you

Communication Preferences ***(Circle One)***

How would you like to be contacted for Appointments	Phone	Text	Email	Mail
Billing Issues	Phone	Text	Email	Mail
Healthcare Questions / Results	Phone	Text	Email	Mail
Messages from your provider	Phone	Text	Email	Mail

Insurance

Medicare Member ID Number _____ **Effective Date** _____

Medicaid Member ID Number _____ **Effective Date** _____

1. Give receptionist your insurance card and CA ID to copy for your chart
2. Turn in Federal poverty level application and proof of income for sliding scale (if self-pay)
3. Receptionist will scan your documents into your chart

Insurance Name (Anthem, Aetna, HealthNet, etc.) _____

Insurance Member ID _____

Subscriber/Member Name on Card _____

Subscriber DOB _____

Effective Date _____

Insurance Group Info:

☐ Nivano
☐ River City Medical Group
☐ Partnership Health
☐ Hill Physicians
☐ Molina
☐ Other _____
(Name of group i.e; Wellspace, One Community, CHCN, Kaiser, etc.)

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge.

PATIENT SIGNATURE **DATE**

Consents & Acknowledgements

Treatment: I consent to the treatment that will be provided by Elica Health Centers' (EHC) providers, as well as their assistants and other EHC staff members. I understand that a medical record will be prepared and maintained about me by the clinic, and that I am entitled to obtain a copy of my medical record by signing a Medical Records Authorization Form provided by the clinic for that purpose. **Initials:** _____

Students/Residents: I understand that EHC participates in the education of students in healthcare. I can decline their participation in my care at any time. **Initials:** _____

Telehealth: I consent to receiving care via telephone, telehealth or patient portal when medically necessary and clinically appropriate to exchange medical information between me and the provider, or between one provider and another provider. **Initials:** _____

Assignment of Benefits: I authorize payment directly to EHC of benefits otherwise payable to me but not to exceed EHC's regular charges for this service. I understand that I am financially responsible to EHC for any charges not covered by my insurance, including the balance of my charges after any discount has been applied. **Initials:** _____

Financial Agreement: I agree to pay all charges that are not payable by insurance or third party. I agree to abide by the terms and conditions of EHC's Collections Policy. Elica Health Centers is not a free clinic and failure to fulfill your financial responsibility to us or agree to a payment schedule may result in your financial discharge from our services. In accordance with EHC's Collection Policy, EHC may choose to terminate its relationship with any patient who does not comply with this financial agreement. **Initials:** _____

Patient Pharmacy Free Choice (As required by U.S. Department of Health and Human Services, Resources and Services Administration (HRSA) and the State of California) I hereby acknowledge that I am free to choose a pharmacy. Any fax or electronic transmission of my prescriptions shall be to the pharmacy or dispensary I select. If I am eligible for medications through a free or discount pharmacy program, I will be directed to a specific dispensary or pharmacy. Elica has free or discounted medications at certain contracted pharmacies. If I chose not to use a contracted pharmacy, I may have that prescription filled at another pharmacy, at a non-discounted price. **Initials:** _____

Notice of Privacy Practices: By signing this form, I acknowledge receipt of the Clinic's Notice of Privacy Practices. **Initials:** _____

Validity of Consent: I understand that this consent will be valid as long as I am a patient or legal guardian of a patient of Elica Health Centers. I have the right to withdraw my consent at any time. If I choose to do so, I must provide that withdrawal in writing to the clinic. The withdrawal of consent will only apply after it is received, and not to any information for which I previously provided consent. **Initials:** _____

Photographs: I consent for photographs to be made of me or my child (or person for whom I am legal guardian). I understand the information will only be used for my health record for identification purposes. **Initials:** _____

Elica Health Centers is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Elica health Centers, OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Elica Health Centers with other OCHIN participants, when necessary for health care operation purposes of the organization is health care arrangement. **Initials:** _____

Open Payments: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. **Initials:** _____

BY SIGNING BELOW, I CONFIRM THAT THE INFORMATION PROVIDED ON THE PATIENT REGISTRATION FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE READ THE CONSENT SECTION, AND UNDERSTAND AND ACCEPT ITS TERMS.

_____ **Print Name of Patient**

_____ **Relationship to patient of Individual Signing Form** (for example, patient, parent, guardian)

_____ **Patient/Guardian Signature**

_____ **Date**

_____ **Witness (Clinic Staff Member)**

_____ **Date**

"Healing with Heart"
Elica Health Centers

PEDIATRIC HEALTH HISTORY AGES 0-12

Patient Name	**MRN:**	**Today's Date** (month/day/year)
Date of Birth (month/day/year)		

ALLERGIES TO ANY MEDICATIONS, FOOD OR OTHER SUBSTANCES?

Allergic to:	**Reaction:**	**Severity of Reaction:**
	☐Anaphylaxis ☐ Hives ☐Rash ☐ Swelling ☐Nausea/ vomiting ☐Other:_____	☐Low ☐Medium ☐High
	☐Anaphylaxis ☐ Hives ☐Rash ☐ Swelling ☐Nausea/ vomiting ☐Other:_____	☐Low ☐Medium ☐High
	☐Anaphylaxis ☐ Hives ☐Rash ☐ Swelling ☐Nausea/ vomiting ☐Other:_____	☐Low ☐Medium ☐High

MEDICAL HISTORY (Check all diseases and medical conditions that apply)

☐No Past Medical History

☐Abuse as Adult (victim)	☐Asthma	☐Depression	☐Heart Failure	☐Liver disease	☐Sickle cell anemia
☐Abuse as a child (victim)	☐Blood Transfusion	☐Diabetes mellitus	☐Heart murmur	☐Meningitis	☐Stomach ulcers
☐Allergies	☐Cancer	☐Emphysema/COPD	☐HIV/AIDS	☐Myocardial infarction	☐Stroke
☐Anemia	☐Cataracts	☐GERD	☐Hyperlipidemia	☐Nerve/Muscle disease	☐Substance abuse
☐Anxiety	☐Clotting disorder	☐Glaucoma	☐Hypertension	☐Osteoporosis	☐TB disease
☐Arthritis/Join disorder	☐COPD	☐Heart disease	☐Kidney disease	☐Seizures	☐Thyroid disease

☐Other, please explain:

SURGICAL HISTORY

☐No Past Surgical History

☐Appendectomy	☐Cosmetic surgery	☐Small intestine surgery
☐Brain surgery	☐Eye surgery	☐Spine surgery
☐Breast surgery	☐Fracture surgery	☐Third Molar Extraction

☐CABG	☐Hernia repair	☐Tonsillectomy
☐Cholecystectomy	☐Joint replacement	☐Valve replacement
☐Colon surgery	☐Prostate surgery	☐Vasectomy
☐Other, please explain:		

FAMILY HISTORY (Check all diseases and conditions that apply)

		No Known Problems	Alcohol/Drug Use	Allergies	Alzheimer's Disease	Anemia	Autoimmune Disease	Breast Cancer	Colon Cancer	Cancer	Depression	Diabetes	Heart Attack	High Cholesterol	Hypertension	Kidney Disease	Liver Disease	Lung Disease	Stroke	Sudden Death	Suicide	Thyroid Disease	Vision Problems	Other
Relationship	**Name**																							
Mother																								
Father																								
Sister																								
Brother																								
Daughter																								
Son																								
Maternal Aunt																								
Maternal Uncle																								
Paternal Aunt																								
Paternal Uncle																								
Maternal Grandmother																								
Maternal Grandfather																								
Paternal Grandmother																								
Paternal Grandfather																								
Other																								

LIST ANY OTHER FAMILY MEDICAL HISTORY BELOW:

Disease or medical problem:	Family member:

Complete for children ages 8-12: SCARED, BRIEF (Child answers)

I get really frightened for no reason at all:	☐Not true or Hardly ever true	☐ Somewhat True or Sometimes True	☐ Very True or Often True
I am afraid to be alone in the house:	☐Not true or Hardly ever true	☐ Somewhat True or Sometimes True	☐ Very True or Often True
People tell me that I worry too much:	☐Not true or Hardly ever true	☐ Somewhat True or Sometimes True	☐ Very True or Often True
I am scared to go to school:	☐Not true or Hardly ever true	☐ Somewhat True or Sometimes True	☐ Very True or Often True
I am shy:	☐Not true or Hardly ever true	☐ Somewhat True or Sometimes True	☐ Very True or Often True

TB RISK ASSESSMENT

Recent close or prolonged contact with someone with infectious TB disease	☐Yes	☐No
Born in or recent traveler to high prevalence area	☐Yes	☐No
Chest radiographs with fibrotic changes suggesting inactive or past TB	☐Yes	☐No
HIV infection	☐Yes	☐No
Organ transplant recipient	☐Yes	☐No
Immunosuppression secondary to use of prednisone (equivalent of > or = to 15mg/day for >or = 1 month) or other immunosuppressive medication such as TNF -α antagonist	☐Yes	☐No
Injection drug user	☐Yes	☐No
Resident or employee of high-risk congregate setting (e.g.,prison, long-term care facility, hospital, homeless shelter)	☐Yes	☐No
Medical condition associated with risk of progressing to TB disease if infected (e.g. diabetes mellitus, silicosis, cancer if head or neck, Hodgkin's Disease, leukemia, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal for given population))	☐Yes	☐No

Signs/Symptoms of TB ☐ Persistent Cough ☐Persistent fever ☐ Unexplained weight loss ☐Loss of appetite ☐ Persistent sweats
☐Chronic fatigue ☐ Chills ☐Coughing up blood ☐ Shortness of breath ☐Chest pain ☐ None

SOCIAL HISTORY (PRAPARE): For Parent or Caregiver

How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?
☐Not hard at all ☐ Somewhat hard ☐ Very hard ☐Decline

What is your living situation today?
☐I have a steady place to live
☐I have a place to live today, but I am worried about losing it in the future
☐I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the streets, on the beach, in the car.)
☐Decline

In the past 12 months, 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 getting medications
☐Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
☐No
☐Declined

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
☐Less than once a week ☐ 1-2 times a week ☐ 3-5 times a week ☐ 5 or more times a week ☐Decline

How often do you experience stress?
☐Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐Decline

Are you currently employed? ☐Yes ☐ No ☐ Decline

Would you like assistance with any of the above items? ☐Yes ☐ No

Type of assistance: ☐ Written information ☐ Contact me

What do you want help with?

☐Health Literacy ☐ Education ☐ Financial Strain ☐Transportation ☐ Employment ☐ Utilities
☐Physical Activities ☐ Stress ☐ Isolation ☐Housing ☐ Food ☐Relationship

MEDICATION
(List all current medications: prescribed, over-the-counter drugs, vitamins & inhalers and the dosage)

Medication	Dosage	Frequency

ARE YOU CURRENTLY UNDER THE CARE OF ANY OTHER PHYSICIANS OR SPECIALISTS?
(LIST ALL BELOW)
Medical Assistant: Complete a medical record release form for all medical providers listed below and add to Care Team in Epic

Physician/Practice Name	Specialty	Address	Phone

DENTAL HISTORY

1. Have you had problems with prior dental treatment?	☐Yes	☐No
2. Date of last dental exam:		
3. Have you ever been premedicated for dental treatment? If yes, why?	☐Yes	☐No
4. Have you taken bisphosphonates?	☐Yes	☐No

ALLERGIES AND REACTIONS		
Are you allergic to Latex? If yes, please explain the reaction.	☐Yes	☐No
Are you allergic to local anesthetic? If yes, please explain the reaction.	☐Yes	☐No
Are you allergic to Nitrous oxide? If yes, please explain the reaction.	☐Yes	☐No

Patient / Legal Guardian Name

Relationship to patient of Individual Signing Form
(example: patient, parent, guardian)

Patient / Legal Guardian Signature

Date

"Healing with Heart" Elica Health Centers

PATIENT PRIVACY

Elica Health Centers (EHC) wants to do all we can to protect your private health information. Telling EHC how you want to share information is called HIPAA Authorization. This form is to help us know what details, if any, you would like us to share with the people in your life. Behavioral Health providers do not/will not communicate with any patients regarding their treatment or care via email and/or text.

Patient Information			
Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:**
Legal Parent/Guardian/ Conservator #1 (if applicable):		**Legal Parent/Guardian/ Conservator #2 (if applicable):**	

Message Preferences: Tell us the type of messages you prefer and what we can share. (Messaging and data rates may apply.)	Phone	Text	Email/Portal
All of the below	☐	☐	☐
Health Notifications (such as lab or test results)	☐	☐	☐
Appointment Reminders	☐	☐	☐
Announcements (such as new programs or community information)	☐	☐	☐
Billing Notifications	☐	☐	☐

Who: Tell us who you would like us to share, or release, information with. Each box is for a different person.

Person #1		**Person #2**	
Name:		**Name:**	
Relationship:		**Relationship:**	
☐ We can tell this person any and all of your medical information.		☐ We can tell this person any and all of your medical information.	
OR		**OR**	
☐ We can give this person today's chart notes at the time of the visit.		☐ We can give this person today's chart notes at the time of the visit.	
☐ We can give this person all of your test results.		☐ We can give this person all of your test results.	
Office Use Only		**Office Use Only**	
Effective Date:	Updated by:	Effective Date:	Updated by:
Revoke Date:	Updated by:	Revoke Date:	Updated by:

Person #3		**Person #4**	
Name:		**Name:**	
Relationship:		**Relationship:**	
☐ We can tell this person any and all of your medical information.		☐ We can tell this person any and all of your medical information.	
OR		**OR**	
☐ We can give this person today's chart notes at the time of the visit.		☐ We can give this person today's chart notes at the time of the visit.	
☐ We can give this person all of your test results.		☐ We can give this person all of your test results.	
Office Use Only		**Office Use Only**	
Effective Date:	Updated by:	Effective Date:	Updated by:
Revoke Date:	Updated by:	Revoke Date:	Updated by:

☐ **I do not want ANYTHING told or shared with ANYONE.**

By signing this form, I acknowledge receipt of the Clinic's **Notice of Privacy Practices** and authorize Elica Health Centers to share my health information to the listed individuals as indicated above.

_____ _____

Print Name of Patient | Relationship to Patient of Individual Signing Form (for example, patient, parent, guardian, caregiver)

_____ _____

Patient/Guardian Signature | Date

_____ _____

Witness (Clinic Staff Member) | Date

"Healing with Heart"
Elica Health Centers

SLIDING FEE DISCOUNT PROGRAM APPLICATION

At Elica Health Centers, we offer a Sliding Fee Discount to make our services more affordable to all patients.

- If you already receive Social Security Disability income (SSDI), Temporary Assistance for Needy Families (TANF), or any other public assistance programs, you may be eligible for the Sliding Fee Discount Program.

The following criteria apply to the sliding fee scale, which is based on the current Federal Poverty Guidelines (FPG):

- You must complete the application on the reverse and re-apply in six months, or when your household or income changes, whichever comes first.
- You are required to provide proof of income as instructed on the application. Self-declaration of income will qualify the patient for one visit only, but can be changed within ten days of visit.
    - If you have no income or are unable to provide proof of income, please fill out the self-declaration form. You may still be eligible for the Sliding Fee Discount Program.
- Approval is based on household size and gross income.
- Participants are expected to pay their share of the discounted fee at the time of service.
    - Patients can also arrange to make regular payments until the balance is paid.
    - A charge for today's services will reflect the sliding fee scale below. If you qualify on the sliding fee scale, this will be your nominal fee and no other charges will be billed.
    - Sources of acceptable payments are:
        1. Cash
        2. Credit Cards (VISA, MasterCard). Checks are not acceptable.

If eligible to enroll in Medi-Cal, please ask us for more information. We would be happy to provide resources such as:

- Evaluation if you are eligible for full scope Medi-Cal
- Assistance with filing the MC-13 PRUCOL form
  (if you only have Emergency Medi-Cal and want to request full coverage)
- Provide Department of Human Assistance location contact information or help schedule a visit with Sacramento Covered
- Provide information and estimate income limits for Medi-Cal or other programs.
- Provide information and help find information about programs (e.g., for oncology, diabetes) if the patient is not eligible for any insurance.

If you have questions, please contact a staff member from one of EHC locations, or call at (916) 454-2345.

SLIDING FEE DISCOUNT SCHEDULE

Elica Health Centers: Sliding Fee Schedule			Sliding Fee Scale: (Based on Federal Register Poverty Income Guidelines)			
Discount Categories	**Category A**	**Category B**	**Category C**	**Category D**	**Category E**	**Full Pricing**
% of Federal Poverty Income Levels	**At or below 100% (FPG)**	**>100 - 125%**	**>125 - 150%**	**>150 - 175%**	**>175 - 200%**	**> 200 %**
Medical / Behavioral Health	**Nominal Fee**	**Discounted Fees**				**Full Pricing**
All Inclusive Visit (1)	**$25**	**$35**	**$45**	**$55**	**$65**	
Internal Diagnostic labs (2)	**$5**	**$6**	**$7**	**$8**	**$9**	
Lab referral (3)	**$30**	**$31**	**$32**	**$33**	**$34**	
Electives & Other Special Items (see schedule below) (4)	**see #4 below**					
Dental Program	**Nominal Fee**	**Discounted Fees**				**Full Pricing**
All Inclusive Visit: diagnostic, preventive, periodontal, & emergencies (1)	**$25**	**$35**	**$45**	**$55**	**$65**	
Major / Bundled Professional fees: bridges, crowns, dentures, & root canals (5)	**$25**	**$35**	**$45**	**$55**	**$65**	
Major / Bundled: lab/equipment (5)	**see schedule below**					

1. All-inclusive visits include professional services and all routine supplies, injectables, and vaccines.
2. Internal labs are medical diagnostic labs performed on site.
3. Lab referrals are medical diagnostic labs performed off site by Quest Diagnostics or other reference labs.
4. Electives and other special items with special pricing (based on actual cost):

   Depo Provera $45 — Other IUDs $600

   Liletta IUD $105 — Night guards $95
5. Major/Bundled Dental includes services such as treatment planning, special labs and/or equipment. These services may be bundled into two or more appointments. An Elica Treatment Coordinator will explain the process and provide financial counseling services. The patient is expected to pay 50% before services can begin and the remaining balance will be set up on a payment plan. See schedule below.

Patient pays discounted professional fee for each visit plus a one-time fee according to this schedule:

Major Service	**Category A**	**Category B**	**Category C**	**Category D**	**Category E**	**Full Pricing**
Root Canal (per canal)	**$175**	**$200**	**$225**	**$250**	**$275**	
Crown/Bridge (per unit)	**$150**	**$170**	**$190**	**$210**	**$230**	
Full Denture (per arch)	**$400**	**$450**	**$500**	**$550**	**$600**	
Partial Denture (per arch)	**$450**	**$500**	**$550**	**$600**	**$650**	

APPLICATION FOR SLIDING FEE PROGRAM ELIGIBILITY

1. Have you applied for Medi-Cal, and been DENIED benefits within the last 60 days? ❒ Yes ❒ No
2. Total Number of dependents living in your household (include yourself/spouse, children, and any taxable dependent relatives living with you: _____

You must provide proof of income for every adult household member. Examples are: a copy of the most recent tax return, your two most current pay stubs or W2's, child support check stubs, social security statements, disability / workers' compensation check stubs, letter of support, etc. Please ask for help in determining acceptable proof of income. You must submit documentation within 10 days of your application. Failure to do so will result in the return of your application and delay in approval.

Patient Name: _____ Birth Date: _____

					For Internal Use Only	
Name	Relationship	Date of Birth	Income Amount	Income Type	Date Received	Type of Documentation
	self			❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		
				❒ Hourly Wage ❒ Monthly Salary ❒ Annual Income		

I hereby request Elica Health Centers to determine my eligibility for the sliding fee program, based on the information I have submitted. I understand that the information, which I submit concerning my family income and size, is subject to verification. I also understand that if the information, which I submit, is determined to be false, I will be liable for all services at full charge. In signing this application, I affirm that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Elica Health Centers of all changes to my insurance information and should I fail to do so, payment in full of all services rendered will be my responsibility.

Signature: _____ Date:_____

VERIFICATION AND DETERMINATION (Office Use Only)

1. Monthly income verification attached: ❒ Yes ❒ No (Initial Self-Declaration)
2. Slide Effective Date: _____
3. Qualified fee reduction: ❒ ≤100% ❒ 101-125% ❒ 126-150% ❒ 151-175% ❒ 176-200% ❒ ≥200%
4. Length of reduction: ❒ 1st Visit ❒ 6 months

Verification and determination by: _____ Date: _____

"Healing with Heart" Elica Health Centers

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name	**MRN:**	**Today's Date** (month/day/year)
Date of Birth (month/day/year)		

SELF-DECLARATION FORM

I, _____, do hereby attest that:

❒ **Option 1: Cash Income**

I am unable to provide proof of income due to the nature of my work. I attest that

I receive _____ per (hour / month / annual / other: _____).
(dollars) (please choose one of the above options)

❒ **Option 2: Letter of Support**

I receive _____ per month from _____ (_____)
(dollars) (supporter's name) (relationship)

❒ **Option 3: No Income**

Neither I nor any other member of my household has any source of income.

❒ **Option 4: Not Applicable**

I am able to provide proof of income, therefore the above options do not apply to me.

By signing below, I agree that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Elica Health Centers of all changes to my income and support.

_____	_____
Patient / Representative Signature	Date
_____	_____
Print Name	Relationship to Patient