Mountain Comprehensive Health Corporation

REGISTRATION FORM

Today's Date:	❑ Whitesburg ❑ Harlan ❑ Leatherwood\Blackey ❑ Owsley ❑ Buckhorn ❑ Isom ❑ Cumberland ❑ Pineville ❑ Middlesboro

PATIENT INFORMATION -> *PLEASE COMPLETE ALL INFORMATION*

Last Name:	First Name:	Middle:	Previous Last Name:	Nickname:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security #: - -	Date of Birth: / /	Sex: ❑ M ❑ F

Physical Address:	City:	State:	ZIP Code:
Mailing Address \ PO Box:	**City:**	**State:**	**ZIP Code:**

Language: ❑ English ❑ Spanish ❑Other	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated	Student Status: ❑ Full-Time ❑ Part-Time

Home Phone: ( )	Daytime Phone: ( )	Alternate Phone: ( )

Email Address:	Mothers Maiden Name:

Are you employed? ❑Full Time ❑Part Time ❑Unemployed ❑Retired ❑Self ❑Active Duty

Employer Name: Employer Phone: ( )

Employer Address:

Primary Care Provider:	Primary Care Giver:

INSURANCE -> *WHICH INSURANCE SHOULD BE BILLED FOR TODAY'S VISIT?*

PRIMARY INSURANCE: ❑ NONE ❑ WORKERS COMP:_____ ❑ AETNA ❑ WELLCARE ❑ MEDICARE
❑ KY MEDICAID ❑ HUMANA ❑ ANTHEM ❑ BLUEGRASS FAMILY HEALTH ❑ OTHER:_____

SECONDARY INSURANCE: ❑ NONE ❑ WORKERS COMP:_____ ❑ AETNA ❑ WELLCARE
❑ MEDICARE ❑ KY MEDICAID ❑ HUMANA ❑ ANTHEM ❑ BLUEGRASS FAMILY HEALTH ❑ OTHER:_____

RESPONSIBLE PARTY -> *WHO IS THE PERSON RESPONSIBLE FOR PAYING TODAY'S BILL?* ❑ Self ❑ Spouse ❑ Parent ❑ Other

Name:

Physical Address:

Mailing Address \ PO Box:

Home Phone: ( ) Social Security #: - - Date of Birth: / /

ARE YOU A CURRENT OR FORMER COAL MINER? ❑Yes ❑No

❑Active Coal Miner ❑Retired Coal Miner ❑Disabled Coal Miner ❑Retired and Disabled Coal Miner (Combined)
❑Inactive Coal Miner (Currently Unemployed) ❑Inactive Coal Miner (Currently Employed Outside of Coal Industry)

Have you ever participated in the National Institute for Occupational Safety and Health's Coal Workers Health Surveillance Program (NIOSH)?
❑ Yes ❑ No ❑ Unsure

Years as an underground miner: _____
Years as a surface miner:_____

FOR OFFICE USE ONLY
Reviewed By:_____ Date:____/____/____

****ATTENTION: PLEASE SCAN TO PATIENT RECORD!****

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?	If YES, what best describes your current situation?	If NO do you live in Public/Assisted Housing
❑ Yes ❑No	❑Staying with Friends/Family ❑ Shelter ❑ Street ❑ Transitional	❑ Yes ❑ No
Are you a Migrant Farm Worker?	**If YES, what describes your current situation?**	**Do you need an Interpreter?**
❑ Yes ❑ No	❑ Migrant ❑ Seasonal	❑ Yes ❑ No

Race: ❑ White ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ More Than One Race

Ethnicity: ❑ Hispanic ❑ Not Hispanic	Veteran: ❑ Yes ❑ No	Number in Household: ___	Annual Household Income:$ _____

****Homeless**: A person who lacks housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and individuals who reside in transitional housing or permanent supportive housing.**

YOU MAY QUALIFY FOR A DISCOUNT!

Sliding Scale may help on charges that are not covered by Medicare, Medicaid, or Private Insurance including items such as glasses, dental, etc. The chart below can be used for medical, optometry, and behavioral health visits only. 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 the receptionist will assist you with enrollment. Please contact the dental department for more information on dental sliding scale.

**2019 Federal Poverty Guidelines*

LEVEL	100% and below	101% - 125%	126% - 150%	151% - 200%	200% and above
CHARGE	$25.00 nominal *(Includes office, lab, and X-ray Charges on date of service.)*	$35.00 *(Includes office, lab, and X-ray Charges on date of service.)*	$50.00 *(Includes office, lab, and X-ray Charges on date of service.)*	$75.00 *(Includes office, lab, and X-ray Charges on date of service.)*	100% of Charges
FAMILY SIZE	INCOME UP TO	INCOME UP TO	INCOME UP TO	INCOME UP TO	INCOME OVER
1	12,490	15,613	18,735	24,980	24,980
2	16,910	21,138	25,365	33,820	33,820
3	21,330	26,663	31,995	42,660	42,660
4	25,750	32,188	38,625	51,500	51,500
5	30,170	37,713	45,255	60,340	60,340
6	34,590	43,238	51,885	69,180	69,180
7	39,010	48,763	58,515	78,020	78,020
8	43,430	54,288	65,145	86,860	86,860
9	47,850	59,813	71,775	95,700	95,700
10	52,270	65,338	78,405	104,540	104,540

FOR FAMILY UNITS OF MORE THAN 10 MEMBERS, ADD $4,420 FOR EACH ADDITIONAL MEMBER.

Sliding Scale may help on charges that are not covered by Medicare, Medicaid, or Private Insurance including items such as glasses, dental, etc.

YES I AM INTERESTED IN SLIDING SCALE

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.

X _____ _____

Patient Signature **Date**

NO I AM NOT INTERESTED IN SLIDING SCALE

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.

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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