The Daily Planet

WEST GRACE HEALTH CENTER AND SOUTHSIDE HEALTH CENTER

Registration/Financial Screening

Date _____

Please let us know what service(s) you are seeking

☐ Medical Care ☐ Behavior Health Treatment ☐ Voter Registration Info
☐ Dental Services ☐ Mental Health ☐ School or Work Physical
☐ Vision Care ☐ Substance Use ☐ TB Test Only

Last name _____ First Name _____ MI ___

DOB _____ Age____ Gender _____

Email _____ SSN _____

Address _____ City _____ State _____ Zip _____

1st Phone # _____ 2nd Phone # _____

Were you referred by someone? If so, who referred you? _____

What is your current living status?

☐ Rent/Own home (self or family) ☐ Live temporarily with family or friends
☐ Live with someone ☐ On the street (abandoned building, encampment, car)
☐ Transitional Housing for homeless ☐ Emergency shelter
☐ Other (please specify): _____

Marital Status: _____

Sexual Orientation: ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Other ☐ Choose Not To Disclose

Ethnicity: _____

Race(s):

☐ Black/African American ☐ Caucasian ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

Are you a **Veteran**?

What is your primary **language**? ☐ English ☐ Spanish ☐ Other: _____

Emergency Contact: Name _____ Relationship _____

Address _____ Phone _____

What type of insurance do you have? (Please check all that apply and be able to provide a card)

☐ Medicaid ☐ Medicare ☐ VA Healthcare
☐ VCC ☐ Other ☐ None

Do you have a Primary Care Medical Doctor?

We have team based care (PCMH) You can select your medical clinician, choose one:

Do you have a Psychiatrist? ____ Are you looking for a Psychiatrist? ____

Have you ever been in Foster Care and are under 26 years old? (You may qualify for Medicaid).

Have you been denied for Medicaid in the last six months? ___

Have you recently (within the past year) lost your health benefits? ___

Are you eligible for insurance coverage through one of the following?

☐ Job ☐ Parent's Job ☐ Spouse's Job
☐ COBRA ☐ Other ☐ Not Eligible

When and where did you last receive healthcare services? _____

EMPLOYMENT

Yourself:

Employer name/address _____ Phone_____

Which of these most closely applies to you? _____

Are you a Migrant Worker (moving from place to place)?

Are you a Seasonal Worker (temporary and part time)?

Within the past year have you:

☐ Lost Job ☐ Changed Jobs ☐ Increased/Decreased Hours ☐ None of these

Are you a student? ☐ Full Time ☐ Part Time

Spouse/Partner Employment:

Employer name/address _____ Phone_____

Which of these most closely applies? _____

The Daily Planet offers discounted fees for services for persons up to 200% of the poverty level; Sliding Fee Discount Schedule. This schedule is based on the Federal Poverty Income Guidelines. If you wish to apply for discounted services proof of income will need to be provided in order to determine if you are eligible for discounted services and/or how much the discount will be. Please see the Fee Payment and Proof of Income Notice form and Sliding Fee Eligibility Documentation Form for detailed information. These forms are in your registration packet.

Household Information (people you are financially responsible for)

Name	Relationship	DOB	Age

Total number of people in your household (including yourself): _____

What is your monthly household income from the following sources (please list all that apply):

$_____ Employment $_____ Unemployment Benefits $_____ Food Stamps

$_____ SSI $_____ Veteran's Benefits $_____ Child Support/Alimony

$_____ SSDI $_____ TANF $_____ Pension/Retirement

$_____ Social Security $_____ Other (please explain): _____

_____ No Income

Total (select one) **Household Income**: _____

If no income in received, how do you provide food and shelter for yourself/family?

Please note: The Daily Planet Behavioral Health clinic **does not provide one-time only** mental health evaluations for court, disability benefits, or other purposes. If you are in need of this service only, we can refer you to another agency that can do it for you. ****_____ **PLEASE INITIAL HERE****

I hereby certify that all information provided on this form is true. I understand that this application will be **reviewed each visit and that proof of income is required annually**, and as income changes. I further understand that, if applicable, I must provide proof of homelessness initially, monthly, and as circumstances change. I understand that if I give false information, withhold information, or fail to report my income, that I could be prosecuted for perjury, larceny, and/or fraud.

_____ _____

Signature Date

_____ _____

Staff Signature Date