For Office Use	
Account#	
Date Received	
Number in HH	
Total Income	
SF Determination	
Staff Initial	
DHS Eligibility ❑ Eligible ❑ Not Eligible ❑ Enrollment Counselor Contacted Patient	

ANNUAL REGISTRATION FORM

PEOPLES Community Health Clinic

905 Franklin Street, Waterloo, IA 50703 (319)272-4300
118 S. Main Street, Clarksville, IA 50619 (319)278-9020

Date:___________________

[PLEASE PRINT]

Name: ____ Date of Birth _____________ **Hispanic?** ❑Yes ❑No

Choose: ❑White ❑Black/African American ❑Asian ❑American Indian/Alaska Native ❑More than one ❑Other_______________

Language Spoken at Home: ❑English ❑Spanish ❑ Bosnian/Serbo-Croatian ❑Burmese ❑Other_____________________

Address: ________________________________City____________________State________Zip__________

Phone No: ____________________ **Do you?** ❑ Own/Rent ❑ Temp Lodging ❑ Shelter ❑ Other __________________

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated Are you a US Citizen? ❑Yes ❑No

Is anyone in the family covered by Medical/Dental insurance? ❑Yes ❑No *If yes, please attach copy of insurance card.*
Is anyone in the family covered by prescription insurance? ❑Yes ❑No *If yes, please attach copy of insurance card.*
Is anyone in the family a veteran? ❑Yes ❑No Who?________________Dates of Service From: ____To: ___
Do you receive public housing assistance? (Section 8) ❑Yes ❑No

Spouse's Name: _________________________________Date of Birth ______________**Hispanic?** ❑Yes ❑No

Choose: ❑White ❑Black/African American ❑Asian ❑American Indian/Alaska Native ❑More than one ❑Other_______________

Dependent's Name: _______________________________Date of Birth ______________**Hispanic?** ❑Yes ❑No

Choose: ❑White ❑Black/African American ❑Asian ❑American Indian/Alaska Native ❑More than one ❑Other_______________

Dependent's Name: _______________________________Date of Birth ______________**Hispanic?** ❑Yes ❑No

Choose: ❑White ❑Black/African American ❑Asian ❑American Indian/Alaska Native ❑More than one ❑Other_______________

Dependent's Name: _______________________________Date of Birth ______________**Hispanic?** ❑Yes ❑No

Choose: ❑White ❑Black/African American ❑Asian ❑American Indian/Alaska Native ❑More than one ❑Other_______________

Dependent's Name: _______________________________Date of Birth ______________**Hispanic?** ❑Yes ❑No

Choose: ❑White ❑Black/African American ❑Asian ❑American Indian/Alaska Native ❑More than one ❑Other_______________

Dependent's Name: _______________________________Date of Birth ______________**Hispanic?** ❑Yes ❑No

Choose: ❑White ❑Black/African American ❑Asian ❑American Indian/Alaska Native ❑More than one ❑Other_______________

(over)

FINANCIAL DISCLOSURE

☐ **I DO NOT WISH TO DISCLOSE MY INCOME. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL CHARGES AND WILL BE ELIGIBLE FOR A PAYMENT PLAN.**

Please sign below and return form.

INCOME INFORMATION (ALL AREAS MUST BE COMPLETED):

Are you or spouse presently employed? . . . ❑ Yes ❑ No *If no, please skip to Other Sources of Income below*
Are you or spouse self-employed? . . . . . ❑ Yes ❑ No *If yes, please attach recent Federal Income Tax Return*

Applicant			**Spouse of Applicant**		
Employer			Employer		
Street Address		Telephone Number	Street Address		Telephone Number
City	State	Zip	City	State	Zip
Hourly Rate	Hours per week		Hourly Rate	Hours per week	

Do you pay alimony/child support? ❑Yes ❑No Paid Monthly$_____

OTHER SOURCES OF INCOME (check type and list amount):

- ❑ Alimony/Child Support - Received Monthly $_____
- ❑ Social Security _____
- ❑ Veteran's Benefits _____
- ❑ Unemployment Compensation _____
- ❑ Educational Stipend _____
- ❑ Pension Annuity _____
- ❑ Workman's Compensation _____
- ❑ Rental Income _____
- ❑ Other (Specify)_____

I declare that my financial status is as listed above. I realize Peoples Community Health Clinic, Inc. is utilizing federal tax dollars to assist me in receiving care. I understand that any misrepresentation of information regarding my income is considered fraud against the United States Government. I understand that it is my responsibility to inform Peoples Community Health Clinic, Inc. of any changes in my insurance or income status in a timely manner. Peoples Community Health Clinic, Inc. may release my financial records and any medical records for audit purposes as needed. I give permission for this information to be shared with the Iowa Department of Human Services if a Notice of Decision regarding Affordable Care Act coverage is not enclosed.

_____

Signature of Patient/Applicant **Date**

Submit the Following Items:
(Please send copies, originals will not be returned)

Financial information is needed for all household members

- ❑ Copy of two most recent paycheck stubs dated within the last three months
- ❑ Verification of monthly income from Social Security if you are retired or on disability
- ❑ Copy of current Unemployment Award Letter
- ❑ Copy of current Federal Tax Return (Must be from the current calendar year and must include Schedule C if claiming Self-Employed)
- ❑ Copy of W-2 (Must be from the current calendar year)
- ❑ Patients with no insurance are encouraged to provide a notice of decision regarding eligibility for insurance through the Marketplace (Affordable Care Act). If you need assistance in processing your application through Healthcare.gov or the Iowa Department of Human Services, please contact one of our Certified Application Counselors at (319)272-4350. The information in this application may be shared with the Iowa Department of Human Services if a Notice of Decision regarding Affordable Care Act coverage is not enclosed.

IF YOU HAVE ANY QUESTIONS,
PLEASE CALL THE BILLING DEPARTMENT AT 319/272-4300,
PRESS 7 FOR BILLING, THEN 1 FOR FINANCIAL ASSISTANCE.