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HEALTHWORKS INTAKE APPLICATION

What you need to provide to apply:

- **Photo Identification**
  - **Examples are Driver's License, State ID, Passport, Student Photo ID**
- **Private Insurance Coverage Card, Medicare Part B Card, Medicare Part D Card, or Medicaid**
- **For Sliding Fee Application**
  - **Required documents to determine household size**:
    - Most recent tax return filed within the last 12 months
    - If you did not file taxes, address verification for all members of the household age 6 & older is required.
      - ✓ To verify address for children ages 6-12 please provide a copy of your child's demographics which can be obtained by logging into your school portal or contacting the secretary at your child's school.
    - Legal documentation for anyone whom the patient or guardian is legally obligated to care for
    - If you are unable to provide a copy of your most recent tax return or if you did not file and need to request a **verification of non-filing**, please contact the IRS office at (844)545-5640 to schedule an appointment at 5353 Yellowstone Road (2nd floor).
  - **To document household income, the following documentation is required if applicable to your household:**
    - Last 30 days' pay stubs
    - If Self-employed: please provide most recent tax return within last 12 months with schedule C attached, or completed HealthWorks self-employment form
    - Employer Statement Form if newly employed or cannot provide pay stubs
    - Current Social Security Benefit Letter
    - Unemployment Letter from Department of Workforce Services
    - Workers Compensation Statement
    - Veterans' Benefit
    - Alimony
    - Child Support (court order or recent payment history printout from child support office)
    - Retirement
    - **If you have no income, we will accept**:
      - A copy of the denied unemployment letter
      - A letter verifying a recent stay at a shelter or other type of public facility
      - A written statement from your physician documenting temporary disability
      - Healthworks Homeless Attestation Form

      ***If none of the above is available, please complete HealthWorks statement of self-declared income**.

PLEASE NOTE: Each agency may have different eligibility rules, requirements, and service fees.

HealthWorks *Where health happens*

Cheyenne Regional Medical Center

University of Wyoming Family Medicine Residency Program at Cheyenne

Peak Wellness Center

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SLIDING FEE DISCOUNT APPLICATION

Tell us about each member of your Household:

Please list every household member claimed on your tax return. (**Please use additional pages if needed.**)

Household Member (relationship to applicant)		Insurance Coverage?	Type of Income for Household Member Gross Total Income Per Month (income before taxes and deductions are taken out)			
☐ Self _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/___ **SSN:** _____-_____-_____ Can anyone claim you as a **dependent** on their tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/Retirement $ _____		☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other ☐No income $ _____ See next section	
☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/___ **SSN:** _____-_____-_____ Is this person is included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/ Retirement $ _____		☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other ☐No income $ _____ See next section	
☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/___ **SSN:** _____-_____-_____ Is this person is included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/ Retirement $ _____		☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other ☐No income $ _____ See next section	

Members of household continued:

Please list every household member claimed on your tax return. (**Please use additional pages if needed.**)

☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/___ **SSN:** _____-_____-_____ Is this person is included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/ Retirement $ _____	☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other ☐No income $ _____ See next section		
☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/___ **SSN:** _____-_____-_____ Is this person is included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/ Retirement $ _____	☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other ☐No income $ _____ See next section		
☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: Last First MI	**Gender ☐M☐F** **Birth Date** ____/____/___ **SSN:** _____-_____-_____ **Is this person is included on your tax return?** **☐ Yes ☐ No**	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/ Retirement $ _____	☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other ☐No income $ _____ See next section		

SLIDING FEE DISCOUNT APPLICATION (Continued)

IF NO INCOME IS INDICATED

If you have no income, please indicate which of the following you can provide as documentation:

☐ A copy of denied unemployment letter **and** copy of employment history from the Department of Workforce Services,
☐ A printout of the "Benefit History" from the Department of Family Services that shows eligibility for the Wyoming SNAP program,
☐ A letter verifying a recent stay at a shelter, or other type of public facility.
☐ A written statement from your physician documenting temporary disability
☐ Statement of Self-Declared Income

Can we provide information about payment arrangements for you?	☐Yes	☐No
Have you recently lost employment? Are you eligible for COBRA benefits? Please list employer _____	☐Yes ☐Yes	☐No ☐No
Are you unable to obtain insurance due to a pre-existing condition?	☐Yes	☐No
Have you ever filed for bankruptcy or do you intend to? If yes, what State? _____ Case #? _____File date? _____ Discharge date? _____ Is the reason for the filing due to medical bills?	☐Yes ☐Yes	☐No ☐No
Would you like us to share your sliding fees scale eligibility with any of the following partners? Please indicate which agencies ☐ HealthWorks Clinic ☐ University of Wyoming Residency Program ☐ HealthWorks Pharmacy ☐ Cheyenne Regional Medical Center ☐ Cheyenne Physicians Group ☐ Peak Wellness Center	☐Yes	☐No

My signature indicates that all the information I have provided is true and correct. I hereby grant permission to this agency to obtain and share the information I have provided for determining eligibility for assistance. I understand that failure to disclose insurance coverage for services provided or any household income will exclude me from receiving discounts and the agencies in which I applied for discounts have the right to full legal recourse to collect full billed charges.

Signature of Responsible Party: _____ **Print Patient Name:** _____

Relationship to Patient: _____ **Date:** _____

Agency Representative: _____ **Date:** _____

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Service Assistance Screening

So, that we may better assist you in applying for additional services please answer the following:

- Are you currently eligible for Medicaid Benefits? ☐ No ☐ Yes……. If **NO**, please answer the following section

Do any of the following apply to you or anyone in your household?

☐ Uninsured child(ren) under the age of 19 ☐ Uninsured adult with children who are under 19 years of age ☐ Uninsured pregnant woman ☐ Uninsured aged, blind, and disabled ☐ Uninsured woman diagnosed with breast or cervical cancer ☐ Uninsured individual with tuberculosis ☐ Woman who recently gave birth and received benefits through the Pregnant Woman program	☐ Medicare beneficiary ☐ Client receiving SSI benefits not enrolled in Medicaid ☐ WIC ☐ CLIMB Wyoming ☐ Connections Corner ☐ Safehouse ☐ Father Factor ☐ Health Assist/Job Assist	☐ Housing assistance ☐ SNAP (food stamps) ☐ Low Income Energy Assistance Program (LIEAP) ☐ CHA utility allowance ☐ TANF (Temporary Assistance for Needy Families) ☐ Recently unemployed

If no income was indicated, please answer the following questions:

How are you supporting yourself?	
Where did you sleep last night?	
What was your last employment date?	
Where did you late work?	
How did you get here today?	
Where did you eat your last meal?	
Do you receive any public assistance?	
Does anyone provide you money monthly to pay your expenses?	☐ No ☐ Yes, Amount of monthly payment provided $ _____

Signature of Responsible Party: _____ Print Patient Name: _____

Relationship to Patient: _____ Date: _____

Initials_____ Pt#_____

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PATIENT INFORMATION

What language do you speak? ☐ English ☐Spanish ☐Other _____ What language do you write? ☐English ☐Spanish ☐Other _____ Did someone complete this form on your behalf? ☐Yes ☐No **SI NECECITA ESTA FORMA EN ESPAÑOL POR FAVOR AVISENOS.**	**Today's Date:** **Social Security #**	**Agency Use Only:** ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐100% Self Pay Annual Income $_____ Household size_____ Eligible from _____thru_____

Legal Last Name	**First Name, Middle Initial**	**Birth Date**	**Gender** M F	Other/Former/Maiden Name(s)
Physical Address	**City**	**State**	**Zip Code**	**County**
Mailing Address/P.O. Box	**City**	**State**	**Zip Code**	**County**
Home Phone	**Message Phone**	**Are you a U.S. Citizen?** ☐Yes ☐No		**Marital Status (check one)** ☐Never Married ☐Married ☐Divorced ☐ Legally Separated ☐Widowed ☐Minor Child
Cell Phone	**Work Number**	**Email Address**		

Race (check all that apply)	**Ethnicity (check one)**	**Housing Information** (check one)	**Are you a Veteran?**
☐Asian ☐African American ☐American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐Other/Multi Racial ☐ White ☐Decline to answer ☐ Unavailable	☐Not Hispanic ☐Hispanic/Latino ☐ Ethnic Black ☐Decline to answer ☐ Unavailable	☐Own ☐Rent ☐HUD/CHA ☐Homeless ☐Rent Free ☐Group Home	☐No ☐Non-Combat ☐Combat

Employment (check one):	Employer Name	Employer Phone Number
☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Student ☐Disabled ☐Retired	Employer Address	Date Hired

(For Dependents, Only) Name of Parent/Guardian	**Patient place of birth (state)**	**May we leave you a voice mail message for future appointments?** ☐YES ☐NO

Annual Income		**Household Size**
☐$0 - $10,000	☐$40,000 - $50,000	_____
☐ $10,000 - $20,000	☐$60,000 - $70,000	
☐$20,000 - $30,000	☐ over $70,000	
☐ $30,000- $40,000		

How did you hear about us?
☐Existing Patient
☐Referral from another provider
☐Referral from family/friend
☐Social Media
☐Traders Shoppers Guide

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INSURANCE INFORMATION

Health Insurance? ☐Yes ☐No	Medicare if yes please include policy # ☐Yes ☐No	Equality Care/Medicaid if yes please include policy # ☐Yes ☐No	Kid Care if yes please include policy # ☐Yes ☐No	Prescription Coverage ☐Yes ☐No
Prescription coverage from Prescription Drug Assistance Program (PDAP)? ☐Yes ☐No		Medicare Part D ☐Yes ☐No	If unemployed, are you eligible for COBRA benefits? ☐Yes ☐No	

Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Birth Date of Policy Holder ___/___/___	Relationship to Patient	Policy Holder SSN
Billing Claims Address:	Customer Service Phone: (____) _____-_____	Employer:	Employer phone: (____) ____-_____

Secondary Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Birth Date of Policy Holder ___/___/___	Relationship to Patient	Policy Holder SSN
Billing Claims Address:	Customer Service Phone: (____) _____-_____	Employer:	Employer phone: (____) ____-_____

Are you seeking medical care because of an accident? ☐Yes ☐No If yes, answer following questions…

Date of accident: / /	Was it a motor vehicle accident? ☐Yes ☐No	Was the accident work related? ☐Yes ☐No	Where did the accident occur?
Workers Compensation number:	If motor vehicle accident, name of auto insurance company and policy number:		Do you have an attorney involved and/or a settlement pending? ☐Yes ☐No

ASSIGNMENT AND RELEASE: I authorize HealthWorks to disclose medical information as necessary to receive payment and assign all benefits, if any, directly to HealthWorks that otherwise might be payable to me for services rendered. I understand HealthWorks may also release medical information about me to physicians or other health care providers who may be involved in my continued care. I understand that this authorization will remain in effect for twelve (12) months. If I choose to seek medical care with another provider, I understand that the treatment and information may still be shared with my insurance or another medical carrier. I understand that HealthWorks will file an initial claim with Medicare, Medicaid, or any other third party insurance, if I have provided and signed the necessary information and/or forms. I understand that I am financially responsible for all my charges whether they are covered by my insurance carrier. I also agree to be responsible for payment of any services rendered if my insurance company takes longer than sixty (60) days from date of service**.** If this occurs, I will be responsible for seeking reimbursement from my insurance company. I authorize the use of this signature on all insurance submissions. I understand that if I fail to make a good faith effort to keep my account current HealthWorks reserves the right to refuse non-acute medical services and to engage a collection agency for any outstanding balances.

Signature of Responsible Party: _____ **Print Patient Name: _____**

Relationship to Patient: _____ **Date: _____**

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Cheyenne Health and Wellness Center (CHWC)

(DBA: HealthWorks, and Prescription Assistance Program (PAP)

CONSENT FOR TREATMENT

Health and Medical Care Consent: I voluntarily consent to and authorize Cheyenne Health and Wellness Center, its employees, agents and affiliates, to provide such medical care (including evaluation, diagnostic procedures, and medical treatment) as may be deemed necessary and appropriate by my physician, his/her designees. CHWC periodically conducts training programs for health care professionals. These persons may be observing or participating in CHWC's treatment programs. They will be under the direction of supervised licensed professionals. I understand that I have the right to refuse to have trainers or students participate in my care.

Wyoming Immunization Registry: I understand that the state of Wyoming maintains an immunization registry. The benefits of the registry are to prevent duplication of immunizations, provide timely notification of immunizations due, and to serve as a backup in case you lose your record of vaccination(s). Immunization records are only accessible by authorized health care providers, and schools.

☐ I authorize CHWC to enter information regarding my (or my child's) immunizations into the Wyoming Immunization Registry.

☐ I choose to no longer have myself (or my child) participate in the Wyoming Immunization Registry and request that my (or my child's) immunizations be removed from the Wyoming Immunization Registry.

Printed Name of Patient: _____

Patient or Authorized Signature: _____**Date**_____

If patient is unable to sign or is a minor, indicate relationship to patient: _____

Emergency contact information: In case of emergency who should we contact?

Name: _____ **Phone: (____)_____-_____** **Relationship to patient:** _____

ACKNOWLEDGEMENT OF PRACTICE'S NOTICE OF PRIVACY PRACTICE

CHWC is committed to protecting the confidentiality of your medical information and is required by law to do so. The Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. By subscribing my name below, I acknowledge that I was provided a copy of the NPP and that I have read (or had the opportunity to read if I so choose) and understand the NPP and agree to its terms.

Patient or Authorized Signature_____**Date**_____

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AUTHORIZATION TO DISCLOSE INFORMATION

For HealthWorks to share your health information with a family member (such as a spouse, parent, child, friend); you must first give HealthWorks written permission to do so. By filling out and signing this form, you give that permission. Healthworks may then share your health information with the individuals whose names you have listed in the "CONTACT" section.

Patient Name: _____

Street Address: _____

City, State, Zip:_____

Home phone: _____ Alternate Phone: _____

I hereby authorize HealthWorks to disclose health information to the following contacts:

CONTACT #1 NAME: _____ RELATIONSHIP _____

Street Address:_____

City, State, Zip: _____

Home Phone: _____ Alternate Phone: _____

CONTACT #2 NAME: _____ RELATIONSHIP TO ME _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Alternate Phone: _____

The information that may be disclosed or discussed:

☐ **All my information**

☐ **All my information (except HIV, mental health, and substance abuse)**

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

By signing this form, I understand that HealthWorks may discuss past, present, or future health care issues with these contact(s) from:

Start date _____ through _____ (end date to not exceed 1 year)

SIGNATURE: _____ Date: _____