ANNUAL PATIENT REGISTRATION FORM

****

As a Federally Qualified Health Center (FQHC), we are required to collect the following information on all the patients we serve. Per federal privacy rules (HIPAA) protected information is kept confidential and is not disclosed, unless authorized by the patient. Thank you for your cooperation and choosing BTAMC as your health care provider.

PLEASE PRINT THE INFORMATION, BELOW.

TODAY'S DATE: ______________________ **DATE OF BIRTH:** ______________________ **SEX:** _____M _____F

PATIENT FULL NAME: ____

ADDRESS: ____

CITY: ____ **STATE:** ___________ **ZIP:** ______________________________

HOME PHONE: ____________________ **CELL PHONE:** ____________________ **WORK PHONE:** ____________________

EMAIL: _________________________________ (please circle) **I DO / I DON'T** authorize BTAMC to leave a detailed message

MARITAL STATUS: _____Single _____Married ____Domestic Partner _____Divorced _____Separated _____Widowed

PRIMARY LANGUAGE: (please circle) ENGLISH SPANISH SIGN LANGUAGE OTHER: __________________

ETHNICITY: (please circle) LATINO/HISPANIC NON-LATINO/HISPANIC NOT REPORTED/REFUSED

RACE: CAUCASIAN AFRICAN AMERICAN ASIAN AMERICAN INDIAN/ALASKA NATIVE HAWIIAN/PACIFIC NATIVE

BI-RACIAL or OTHER: ____________________________

FINANCIAL RESPONSIBILITY (Guarantor) & INSURANCE INFORMATION (Please provide insurance cards)

Relationship to Patient: _____Self/Same as Patient _____Spouse/Partner _____Parent OTHER: __________________

Guarantor's Name: ____

Guarantor's Address: ____

Guarantor's PHONE: ____________________ **Guarantor's CELL:** ____________________ **SEX:** _____M _____F

Patient's Insurance: _________________________________ **Insurance ID#:** __________________________________

Guarantor/Policy Holder: _____________________________ **Insurance Group#:** ______________________________

Guarantor's Date of Birth: __________________________ **Subscriber's Social Security#:** ________________________

Pharmacy: _________________________________ **Mail Order Pharmacy:** _________________________________

PLEASE CIRCLE FAMILY SIZE & ESTIMATE ANNUAL HOUSEHOLD INCOME LEVEL FOR 2023

We ask income information because we receive federal funding for assistance programs that benefit patients with lower incomes.

Family Size	From To	From To	From To	From To	From To	Above
1	$0 - $14,580	$14,581 - $18,225	$18,226 - $21,870	$21,871 - $25,515	$25,516 - $29,160	$29,161 +
2	$0 - $19,720	$19,721 - $24,650	$24,651 - $29,580	$29,581 - $34,510	$34,511 - $39,440	$39,441 +
3	$0 - $24,860	$24,861 - $31,075	$31,076 - $37,290	$37,291 - $43,505	$43,506 - $49,720	$49,721 +
4	$0 - $30,000	$30,001 - $37,500	$37,501 - $45,000	$45,001 - $52,500	$52,501 - $60,000	$60,001 +
5	$0 - $35,140	$35,141 - $43,925	$43,926 - $52,710	$52,711 - $62,495	$62,496 - $70,280	$70,281 +
6	$0 - $40,280	$40,281 - $50,350	$50,351 - $60,420	$60,421 - $70,490	$70,491 - $80,560	$80,561 +
7	$0 - $45,420	$45,421 - $56,775	$56,776 - $68,130	$68,131 - $79,485	$79,486 - $90,840	$90,841 +
8	$0 - $50,560	$50,561 - $63,200	$63,201 - $75,840	$75,841 - $88,480	$88,481 - $101,120	$101,121 +

"The mission of Broad Top Area Medical Center, Inc. is to provide access to affordable, high-quality care without discrimination."

Broad Top Health & Wellness

BTAMC Inc.

ANNUAL PATIENT REGISTRATION FORM

****

As a Federally Qualified Health Center (FQHC), we are required to collect the following information on all the patients we serve. The data you provide is for continued grant funding and your personal information is not reported. You may choose not to disclose some information, below. Please select "Not Reported/Refused". Thank you for your cooperation and choosing BTAMC as your health care provider. PLEASE CIRCLE YOUR ANSWERS

Education Completed: _____ High School/GED _____ Some College/Trade School _____Business School/College Degree

Employment Status: _____Yes/Full-time _____Yes/Part-time _____No _____No/Retired _____ I am a Military Veteran

_____Self Employed _____I am a Migratory Worker with a Residence _____I am a Seasonal Worker without a Residence

Shelter Status: _____Public Housing _____Doubling-up/Transitional _____Shelter _____Street _____Not Homeless

Student Status: _____Full-time _____Part-time **Sex at Birth:** _____M _____F _____Not Reported/Refused

Gender Identity: _____M _____F _____Transgender Female to Male _____Transgender Male to Female _____Other

_____Uncertain/Don't Know _____Not Reported/Refused

Sexual Orientation: _____Heterosexual/Straight _____ Homosexual/Lesbian/Gay _____Bisexual _____Other

_____Uncertain/Don't Know _____Not Reported/Refused

EMERGENCY CONTACTS & CONSENT TO SHARE PERSONAL HEALTH INFORMATION

Relationship to Patient: _____Spouse/Partner _____Parent/Legal Guardian _____Child _____________________Other

Contact's Name: ____

Contact's PHONE: ____________________ **Contact's CELL:** ____________________ **OTHER:** _____________________

I authorize BTAMC to share my personal health information with the named persons, as designated below.

Name:____________________________________ **PHONE:** ____________________ **Relationship:** ________________

_____Medical _____Billing _____Scheduling _____All

Name:____________________________________ **PHONE:** ____________________ **Relationship:** ________________

_____Medical _____Billing _____Scheduling _____All

Name:____________________________________ **PHONE:** ____________________ **Relationship:** ________________

_____Medical _____Billing _____Scheduling _____All

TREATMENT & PAYMENT AUTHORIZATION

As a patient of BTAMC, I authorize treatment for myself, or the identified minor. I consent to clinical assessment, treatment, testing or tele-health services, including audio/visual or audio only encounter. I understand examination and treatment may be from providers such as, physicians, physician's assistants, nurse practitioners, clinical social workers, interns, or students under supervision of a doctor, or other, licensed professionals. I authorize BTAMC to release my medical information for the continuum of care with other medical providers and facilities, or with payors to determine insurance benefits.

I understand that I am financially responsible for all service charges for myself or identified minor, whether or not the service(s) are covered by insurance. As a courtesy, BTAMC will submit claims to an insurance company on my behalf. I understand charges not covered by insurance such as, co-pays, co-insurance, deductibles or sliding fees are my responsibility. I understand that I may apply for Sliding Fee Discounts or set up payment arrangements with the BTAMC Billing Department. I understand any checks returned by my financial institution will incur a $25.00 charge.

PATIENT / GUARDIAN SIGNATURE: ____ **DATE:** _____________________

STAFF WITNESS: ____ **DATE/ENTRY:** ________________

Broad Top Area Medical Center, Inc.

2023 SLIDING FEE SCALE DISCOUNT PROGRAM – PATIENT EDUCATION & APPLICATION PACKET

FEDERAL POVERTY GUIDELINES

Broad Top Area Medical Center Inc., (BTAMC) is a non-profit Federally Qualified Health Center, our Mission is to provide access to affordable, high-quality healthcare without discrimination based on one's race, color, sex, disability, age, creed, or national origin. BTAMC will provide in-scope services to all patients, regardless of their insurance status or ability to pay. Every patient may apply for our Sliding Fee Scale Discount Program (SFS) to determine qualification. Patients may choose to decline the benefit program.

Eligibility for Sliding Fee Discounts is based on the federal poverty level (FPL) income guidelines which are adjusted annually and operate in accordance with other federal program regulations. **All** patients are encouraged to apply. Uninsured and under-insured patients may qualify for the program based on their household size and their family's income. Sliding Fee Scale Discount Program applications are available on-line or at our reception desks.

Important discount program points are:

- The Sliding Fee Scale provides significant discounts for BTAMC's **Medical** and **Dental** services.
- The Sliding Fee Scale **is not** an insurance program – it is a benefit offered to ALL patients.
- You may qualify for the program, even if you have medical insurance coverage.
- You must apply for the program to determine eligibility for Sliding Fee Scale Discounts
- You must provide documentation for proof of income to complete the application process.
- Your eligibility is based on the gross income for your household and your household size.
- You are encouraged to re-apply anytime your household income or household size changes, such as when someone becomes unemployed, or you add a family member – even then the change is temporary.
- **You must renew applications and submit proof of income, annually.**
- The Sliding Fee Scale benefit year is from **March 1st to the last day of February**.
- Applications & questions can be submitted to the office in person, by mail or via secure Email to: enrollment@broadtopmedical.com

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA
* For families/households with more than 8 persons, add **$5,140** for each additional person.

Please Circle Your Family Size & Estimated Household Income Level

We ask income information because we receive federal funding for assistance programs that benefit patients with lower incomes.

	Slide A (<=100%)	Slide B (101% - 125%)	Slide C (126% - 150%)	Slide D (151% - 175%)	Slide E (176% - 200%)	Above 200% FPL
Family Size	From To	From To	From To	From To	From To	
1	$0 - $14,580	$14,581 - $18,225	$18,226 - $21,870	$21,871 - $25,515	$25,516 - $29,160	$29,161 +
2	$0 - $19,720	$18,721 - $24,650	$24,651 - $29,580	$29,581 - $34,510	$34,511 - $39,440	$39,441 +
3	$0 - $24,860	$24,861 - $31,075	$31,076 - $37,290	$37,291 - $43,505	$43,506 - $49,720	$49,721 +
4	$0 - $30,000	$30,001 - $37,500	$37,501 - $45,000	$45,001 - $52,500	$52,501 - $60,000	$60,001 +
5	$0 - $35,140	$35,141 - $43,925	$43,926 - $52,710	$52,711 - $62,495	$62,496 - $70,280	$70,281 +
6	$0 - $40,280	$40,281 - $50,350	$40,351 - $60,420	$60,421 - $70,490	$70,491 - $80,560	$80,561 +
7	$0 - $45,420	$45,421 - $56,775	$56,776 - $68,130	$68,131 - $79,485	$79,486 - $90,840	$90,841 +
8	$0 - $50,560	$50,561 - $63,200	$63,201 - $75,840	$75,841 - $88,480	$88,481 - $101,120	$101,121 +

☐ **I understand that I may qualify for the Sliding Fee Discount Program but at this time, I choose to decline.**

____ ____

Print Name Date of Birth Signature Date

____ ________________________

Witness Date

Broad Top Area Medical Center, Inc.

2023 SLIDING FEE SCALE DISCOUNT PROGRAM – PATIENT EDUCATION & APPLICATION PACKET

Applicant's Information:

First Name: Middle: Last:

____

Home Address: City: State: Zip:

____

Mailing Address: City: State: Zip:

____

Home Phone #: Cell Phone #: Work Phone #:

____

Date of Birth: Social Security #: Marital Status: (Circle One)

____ Single Married Domestic Partnership

Divorced Separated Widowed/Widower

____

Note: To comply with federal regulations, and to determine eligibility for discounted services, it is necessary to ask some personal questions. Your answers will be kept on file in strict confidence. To qualify for the Sliding Fee Scale Discount Program (SFS) we must verify your gross income every benefit year, from March 1 to the last day of February.

Proof of income can be verified by presenting us with your income tax return from previous year, last month's paycheck stubs, copies of your unemployment or social security determination, or bank statement of deposit will be sufficient proof.

Your household size and household income will be used to calculate your eligibility for discount. For the purposes of income determination, a family is defined as an individual **or** a group of two or more persons related by birth, marriage, domestic partnership, adoption, or guardianship that live in your household.

Household Size:

FAMILY MEMBER'S NAMES	DATE of BIRTH:	SOCIAL SECURITY NUMBER:
______________________	_____ / _____ / _____	_______ - _______ - _______
______________________	_____ / _____ / _____	_______ - _______ - _______
______________________	_____ / _____ / _____	_______ - _______ - _______
______________________	_____ / _____ / _____	_______ - _______ - _______
______________________	_____ / _____ / _____	_______ - _______ - _______
______________________	_____ / _____ / _____	_______ - _______ - _______
______________________	_____ / _____ / _____	_______ - _______ - _______
______________________	_____ / _____ / _____	_______ - _______ - _______

Broad Top Area Medical Center, Inc.

2023 SLIDING FEE SCALE DISCOUNT PROGRAM – PATIENT EDUCATION & APPLICATION PACKET

Wage Income that Contributes to the Household:

NAME	EMPLOYER	FREQUENCY (Circle One)	AMOUNT
You:		Weekly Bi-Weekly Monthly Yearly	$
Spouse/Partner:		Weekly Bi-Weekly Monthly Yearly	$
Children:		Weekly Bi-Weekly Monthly Yearly	$
Other:		Weekly Bi-Weekly Monthly Yearly	$
Other:		Weekly Bi-Weekly Monthly Yearly	$
		Total Wage Income:	$

Other Income that Contributes to the Household:

	You	Spouse/Partner	Children	Other	Subtotal
Unemployment Benefits					$
Social Security Benefits					$
Retirement or Pension Benefits					$
Alimony or Child Support					$
Royalty or Annuity Payment					$
Other Income					$
Cash, Heat, or Food Assistance	YES	NO	(Not counted as taxable income for Sliding Fee Scale)		
				Total of Other Income:	$
				Total of Wage Income:	$
				ANNUAL HOUSEHOLD INCOME:	**$**

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the SFS Program and may subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform BTAMC if there is a significant change in my income. If my application is approved and qualified for the SFS Program, I will comply with all BTAMC rules and regulations.
I hereby acknowledge that I have read the foregoing disclosure and understand it.

____ ________________________

Print Name of Applicant or Parent/Guardian Date

____

Signature of Applicant or Parent Guardian:

PLEASE INDICATE SERVICE TYPE:

MEDICAL __________
DENTAL __________
BOTH __________