Eske ou ekri dokiman legal e chawzi gyou moun pou pran desizion pou ou an ka ke gyou bagaj ta janm rive-w? □ Wi □ Non
Si Wi, èske ou kapab ban nou yon kopi? □ Wi □ Non
Non, eske ou vle fom nan? □ Wi □ Non

Adrès Email:

FDOH-PBC
Registration/Eligibility Form
To be filed under eligibility

Florida HEALTH
Palm Beach County

Pati-1: ENFOMASYON SOU KLIYAN-AN

Siyati | **Premye Non ou** | **Dezyem Non ou** | **Sifix**

Dat ou Fèt: (mwa/jou/ane) | **Nimewo Sosyal Sekirite:**

Sèks (√): □ Gason □ Fi □ Change seks | **Lang (√):** □ Angle □ Espayòl □ Kreyòl □ Lòt (Detay) | **Ispanic?:** □ Wi □ Non

Ras: Tcheke √ tout kategori rasyal ki aplike: □ Nwa/Afriken/Ameriten □ Blan □ Ameriken Indien/Natif alasken □ Azyatik □ Natif natal Awayi □ Lòt Abitan Zil Pasifik □ Japonè □ Chinwa □ Guamanian oswa Charmorro □ Filipino □ Vietnamien □ Korean □ Samoan

Note to Clerk: If more than one race is selected use the "Multiracial" button to record all races selected.

Peyi ou fet (√): □ Etazini □ Lòt (Detay): | Dat nan Etazini:

Eské'w té fêt pou kont ou? □ Wi □ Non | Si non: □ Jimo □ Triplèt □ Lòt (Detay) | Eské ou té fèt □ Premye □ Dezyèm □ Lòt (Detay)

Nan tout adrès yo Mete Vil, Eta, ak Kòd Postal

Adres kote ou rete:

Adrès koté'w résévwa lèt si'l diféran dé koté'w rété a:

Nimewo Telefon: Selilè □ Lakay | **Nimewo Telefon:** □ Travay □ Faks

Lot adres ak nimewo telefon pou kominikasyion sou sante ou:

Pati-2: KONTAK POU IJANS

Nom: | Relasyon: | Nimewo Telefon: □ Selilè □ Lakay □ Travay

Pati-3: ASIRANS MEDIKAL (√)

□ **Medicaid** □ **Medicare** □ **HCD** □ **Healthy Palm Beaches** □ **Oken** □ **Lòt (Detay):**

Pati-4: ENFOMASYON FINASYE KAY LA

Sèlman ranpli seksyon sa a si ou vle patisipe nan yon plan peman ki baze sou kapasite finansye ou! Pou kalifye pou plan peman sa a, ou dwe gen prèv revni pou tout manm fanmi an kap travay. (Men kèk egzanp sou prèv: 2 souch chèk aktyèl, fòm W-2, lèt chomaj, sekirite sosyal, AFDC, sipò pou timoun, konpansasyon pou travayè, travay endepandan, pansyon alimantè)

Non moun ki Chèf fanmi en, oswa moun kap peye bill yo: (Si li diferan de non kliyan)	**Mari/Madanm:** (Si li diferan de non kliyan)
Sèks: □ G □ F Dat ou Fèt: (mwa/jou/ane)	Sèks: □ G □ F Dat ou Fèt: (mwa/jou/ane)
Ki non konpayi wap travay pou li a:	Ki non konpayi wap travay pou li a:
Kombyen lajan ou fè chak mwa avan taks:	Kombyen lajan ou fè chak mwa avan taks:
Sous lajan wap résévwa:	Sous lajan wap résévwa:
Depans pou gaderi:	Depans pou gaderi:

Ekri non tout manm fanmi ki depann de ou:

Pitit #1 Nom: _____ Sèks: □ G □ F Dat ou Fèt: (mwa/jou/ane)	Pitit #3 Nom: _____ Sèks: □ G □ F Dat ou Fèt: (mwa/jou/ane)
Pitit #2 Nom: _____ Sèks: □ G □ F Dat ou Fèt: (mwa/jou/ane)	Pitit #4 Nom: _____ Sèks: □ G □ F Dat ou Fèt: (mwa/jou/ane)

Eske ou ap peye sipo po timoun? □ Wi □ Non | Si wi, kombyen ou peyé chak mwa? $

Eske ou ansent oubyen gen lot moun nan kay la ki ansent? □ Wi □ Non | Si Wi, Ki moun: _____ Dat Akouchman: Konbyen ti bebe:

MWEN SETIFYÉ KÉ ENFÒMASYON KI ANWO A KÒRÈK SÉLON TOUT SA MWEN KONNEN. MWEN BAY KONSANTMAN'M POU DÉPATMANSANTÉ PIBLIK LA KA VÉFIYÉ ENFÒMASYON MWEN BAY YO. MWEN KONPRANN KE BAY ENFÒMASYON KI FO OSWA KI PA KÒRÈK KA FÈ MWEN PA KALIFYE POU SÈVIS YO BAY NAN KLINIK LA OUBYEN MWEN KA OBLIJE PEYE 100% NAN BÒDWO A.

Kliyan/Paran/Responsab siyati: □ Kliyan □ Paran □ Responsab **Dat:**

PBCHD Official Use Only: Registered by: _____

Facility: □Belle Glade □Centering Program □Delray □Homeless Resource Ctr □Jupiter □Lantana/LW □Northeast □WPB

Do you have an Advance Directive? □ Yes □ No
If Yes, can you provide us a copy? □ Yes □ No
If No, do you want the form? □ Yes □ No

Email:

FDOH-PBC
Registration/Eligibility Form
To be filed under eligibility

Florida HEALTH
Palm Beach County

Part-1: Client Information

Last Name **First Name** **Middle Name** **Suffix**

Date of Birth: (mm/dd/yyyy) **Social Security#:**

Gender (✓): □ Male □ Female □ Transgender **Language (✓):** □ English □ Spanish □ Creole □ Other (Specify) **Hispanic?** □ Yes □ No

Race: Check ✓ all racial categories that apply: □ Black or African American □ White □ American Indian or Alaska Native □ Asian □ Native Hawaiian □ Other Pacific Islander □ Japanese □ Chinese □ Guamanian or Charmorro □ Filipino □ Vietnamese □ Korean □ Samoan

Note to Clerk: If more than one race is selected use the "Multiracial" button to record all races selected.

Country of Birth (✓): □ USA □ Other (Specify): Date to USA:

Were you a single birth? □ Yes □ No If NO, are you a: □ Twin □ Triplets □ Other (Specify): Were you born? □ First □ Second □ Other (Specify):

On All Addresses Include the City, State, and Zip Code

Living Address:

Mailing Address: (If different from where you live)

Phone#: □ Cell □ Home **Phone#:** □ Work □ Fax

Alternate Address and Telephone number for Health Care Communications:

Part-2: Emergency Contact

Name: Relationship to Patient: Phone#: □ Cell □ Home □ Work

Part-3: Health Insurance (√)

□ **Medicaid** □ **Medicare** □ **HCD** □ **Healthy Palm Beaches** □ **None** □ **Other (Specify):**

Part-4: Household Financial Information

Only complete if you want to participate in our Sliding Fee Scale. To qualify for the Sliding Fee Scale you must have proof of income for all working family members. (Examples of proof: 2 current paystubs, W-2 form, unemployment letter, social security, AFDC, child support, workmens comp, self-employment, alimony)

Head of Household or Payor Name: (If different than patient)	**Spouse's Name:** (If different than patient)
Sex: □ M □ F Date of Birth: (mm/dd/yyyy)	Sex: □ M □ F Date of Birth: (mm/dd/yyyy)
Employer's Name:	Employer's Name:
Monthly Gross Income:	Monthly Gross Income:
Type of Income:	Type of Income:
Monthly Child Care Expense:	Monthly Child Care Expense:

List all dependent family members:

Child #1 Name: _____ Sex: □ M □ F Date of Birth: (mm/dd/yyyy)	Child #3 Name: _____ Sex: □ M □ F Date of Birth: (mm/dd/yyyy)
Child #2 Name: _____ Sex: □ M □ F Date of Birth: (mm/dd/yyyy)	Child #4 Name: _____ Sex: □ M □ F Date of Birth: (mm/dd/yyyy)

Are you making any payments for child support? □ Yes □ No If yes, how much is paid each month? $

Are you or any of the family members pregnant? □ Yes □ No If yes, Who: _____ Due Date: # of Babies Due:

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY CONSENT TO THE PALM BEACH COUNTY HEALTH DEPARTMENT, TO VERIFY THE INFORMATION PROVIDED. I UNDERSTAND THAT GIVING FALSE OR INACCURATE INFORMATION MAY MAKE ME INELIGIBLE FOR SERVICES PROVIDED BY THE CLINIC OR I MAY BE REQUIRED TO PAY 100% OF THE BILL.

Client/Parent/Guardian Signature: □ Client □ Parent □ Guardian **Date:**

PBCHD Official Use Only: Registered by: _____

Facility: □Belle Glade □Centering Program □Delray □Homeless Resource Ctr □Jupiter □Lantana/LW □Northeast □WPB