Florida HEALTH Palm Beach County

DOH-PBC Registration/Eligibility Form

To be filed under eligibility

Pati-1: ENFOMASYON SOU KLIYAN-AN

Siyati | Premye Non ou | Dezyem Non ou | Sifix

Dat ou Fèt: (mwa/jou/ane) | Sèks (√): ☐ Gason ☐ Fi ☐ Change seks - Sèks nan nesans: ☐ Gason ☐ Fi | Nimewo Sosyal Sekirite:

Adrès Email: | Peyi ou fet (√): ☐ Etazini ☐ Lòt (Detay): | Dat nan Etazini:

Èske ou genyen yon Dirèktiv Medikal Sou Lavi ou (Direktiv Alavans)? ☐ Wi ☐ Non | Si Wi, èske ou kapab ban nou yon kopi? ☐ Wi ☐ Non Non, eske ou vle fom nan? ☐ Wi ☐ Non | Lang (√): ☐ Angle ☐ Espayòl ☐ Kreyòl ☐ Lòt (Detay)

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

Ispanic?: ☐ Wi ☐ Non Si wi, chwazi youn: ☐ Meksiken oswa Meksiken Ameriken ☐ Pòtoriken ☐ Kiben ☐ Lòt Panyòl oswa Latino/a oswa orijin Panyòl

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: ☐ 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 ☐ Health Care District ☐ BC/BS ☐ Molina ☐ Clear Health Alliance ☐ Oken ☐ Lòt (Detay):

Pati-4: ENFOMASYON FINASYE KAY LA

SI OU TA RENMEN POU ANILE PWOSESIS POU PAYE YON TI KRAS LAJAN, TANPRI METE SIYATI OU LA: _____ ANILE. Lè w fè sa, ou dakò peye frè konplè pou tout sèvis ou resevwa epi sèvis yo pap koute pou yon ti kraze ak pousantaj rabè ki baze sou gwosè fanmi ou ak lajan ou fè. (Note to clerk: No income needed if client waives)

Si ou ta renmen patisipe nan Pwosesis Pou Paye yon ti kras lajan ki baze sou gwosè fanmi ou ak lajan ou fè, ou dwe bay "Prèv sou Revni ou" jodi a, ki baze sou bagay sa yo:

LAJAN OU TOUCHE PA MWA ANVAN TAKS: Lis lajan, poubwa ak salè ou resevwa chak mwa nan tout travay aktyèl yo.

LAJAN OU TOUCHE PA MWA ANVAN TAKS KI PA SOTI NAN TRAVAY: Lis lajan ki soti tout kote excepte nan travay. (Egzanp: Tout kalite benefis Social Sekirite, kompensation pou moun ki pap travail, Pansyon alimantè, Konpansasyon Travayè, Pansyon pou Veteran, Lòt Pansyon ak Pansyon Anyèl. (Pa mete lajan ki soti nan SSI oswa TANF)

NON TOUT MOUN NAN FANMI LAN	Dat ou Fèt: (mwa/jou/ane)	SÈKS	Chèf KAY LA (TCHEKE YON)	ANPLWAYÈ oswa LOT KALITE LAJAN OU TOUCHE	LAJAN SIPÒ POU TIMOUN OU RESEVWA	LAJAN OU TOUCHE PA MWA ANVAN TAKS	LAJAN OU TOUCHE PA MWA ANVAN TAKS KI PA SOTI NAN TRAVAY	KANTITE LAJAN OU PEYE POU GADRI
Pwòp tèt ou		☐ G ☐ F	☐			$	$	
Mari/Madanm		☐ G ☐ F	☐			$	$	
Pitit #1 Nom		☐ G ☐ F			$	$	$	$
Pitit #2 Nom		☐ G ☐ F			$	$	$	$
Pitit #3 Nom		☐ G ☐ F			$	$	$	$
Pitit #4 Nom		☐ G ☐ F			$	$	$	$
Pitit #5 Nom		☐ G ☐ F			$	$	$	$
Pitit #6 Nom		☐ G ☐ F			$	$	$	$

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 BÒOWO A.

Kliyan/Paran/Responsab siyati: ☐ Kliyan ☐ Paran ☐ Responsab Dat:

PBCHD Official Use Only: Registered by:_____ **Date:**_____

Facility: ☐Belle Glade ☐Centering Program ☐Delray ☐Jupiter ☐Lantana/LW ☐Northeast ☐WPB

Florida HEALTH Palm Beach County

FDOH-PBC Registration/Eligibility Form

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Part-1: Client Information

Last Name	First Name	Middle Name	Suffix

Date of Birth: (mm/dd/yyyy)	Gender (✓): □ Male □ Female □ Transgender-Gender at birth: □ Male □ Female	Social Security#:

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

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

Language (✓): □ English □ Spanish □ Creole □ Other (Specify):

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

Hispanic? □ Yes □ No **If yes, select one** □ Mexican or Mexican American or Chicano/a □ Puerto Rican □ Cuban □ Another Hispanic or Latino/a or Spanish origin

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#: □ 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** □ **Health Care District** □ **BC/BS** □ **Molina** □ **Clear Health Alliance** □ **None** □ **Other (Specify):**

Part-4: Household Financial Information

IF YOU WOULD LIKE TO WAIVE THE SLIDING FEE PROCESS PLEASE INITIAL HERE _____ WAIVED. By doing this you are agreeing to pay full fee for all your services and your services will not be provided at a discounted rate based on the family size and income. (Note to clerk: No income needed if client waives)

If you would like to participate in the Sliding Fee Process you must provide "Proof of Income" today, based on the following:

MONTHLY GROSS EARNED INCOME: List wages, tips, salaries received monthly from all current employment.

MONTHLY GROSS UNEARNED INCOME: List monies received monthly from sources other than employment. (Examples: All types of Social Security benefits, Unemployment Compensation, Alimony, Workers' Compensation, Veteran's Pension, and Pensions and Annuities. (Do not include SSI or TANF)

FAMILY MEMBERS NAME	DATE OF BIRTH (MM/DD/YYYY)	SEX	HEAD OF HOUSEHOLD (CHECK ONE)	EMPLOYER or OTHER TYPE OF INCOME	CHILD SUPPORT RECEIVED	MONTHLY GROSS EARNED INCOME	MONTHLY GROSS UNEARNED INCOME	AMOUNT PAID FOR CHILDCARE
SELF		□ M □ F	☐			$	$	
SPOUSE		□ M □ F	☐			$	$	
CHILD #1		□ M □ F			$	$	$	$
CHILD #2		□ M □ F			$	$	$	$
CHILD #3		□ M □ F			$	$	$	$
CHILD #4		□ M □ F			$	$	$	$
CHILD #5		□ M □ F			$	$	$	$
CHILD #6		□ M □ F			$	$	$	$

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:_____ **Date:**_____

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