

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

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



Email: _____

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