



# DOH-PBC Registration/Eligibility Form

To be filed under eligibility

## Part-1: Client Information

Last Name	First Name	Middle Name	Suffix
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Date of Birth: <small>(mm/dd/yyyy)</small>	Gender (J): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender-Gender at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security#:
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Email:	Country of Birth (J): <input type="checkbox"/> USA <input type="checkbox"/> Other (Specify):	Date to USA:
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Do you have a Living Will (Advance Directive)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, can you provide us a copy? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, do you want the form? <input type="checkbox"/> Yes <input type="checkbox"/> No	Language (J): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other (Specify):
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Race: Check (J) 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 Chamorro  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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, are you a: <input type="checkbox"/> Twin <input type="checkbox"/> Triplets <input type="checkbox"/> Other (Specify):	Were you born? <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Other (Specify):
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### On All Addresses Include the City, State, and Zip Code

Living Address:

Mailing Address: (If different from where you live)

Phone#:	<input type="checkbox"/> Cell <input type="checkbox"/> Home	Phone#:	<input type="checkbox"/> Cell <input type="checkbox"/> Home	Phone#:	<input type="checkbox"/> Work <input type="checkbox"/> Fax
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Alternate Address and Telephone number for Health Care Communications:

## Part-2: Emergency Contact

Name:	Relationship to Patient:	Phone#:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
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## 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 <small>(MM/DD/YYYY)</small>	SEX	HEAD OF HOUSEHOLD <small>(CHECK ONE)</small>	EMPLOYER or OTHER TYPE OF INCOME	CHILD SUPPORT RECEIVED	MONTHLY GROSS EARNED INCOME	MONTHLY GROSS UNEARNED INCOME	AMOUNT PAID FOR CHILDCARE
SELF		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>			\$	\$	
SPOUSE		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>			\$	\$	
CHIL0 #1		<input type="checkbox"/> M <input type="checkbox"/> F			\$	\$	\$	\$
CHIL0 #2		<input type="checkbox"/> M <input type="checkbox"/> F			\$	\$	\$	\$
CHIL0 #3		<input type="checkbox"/> M <input type="checkbox"/> F			\$	\$	\$	\$
CHIL0 #4		<input type="checkbox"/> M <input type="checkbox"/> F			\$	\$	\$	\$
CHIL0 #5		<input type="checkbox"/> M <input type="checkbox"/> F			\$	\$	\$	\$
CHIL0 #6		<input type="checkbox"/> M <input type="checkbox"/> 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