



# FDOH-PBC Registration/Eligibility Form

To be filed under eligibility

Do you have an Advance Directive?  Yes  No  
If No, do you want the form?  Yes  No

### Part-1: Patient Information

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Last Name/Suffix \_\_\_\_\_

Date of Birth mm\_\_\_\_-dd\_\_\_\_-yyyy\_\_\_\_\_

Gender:  Male  Female  Transgender

Social Security# \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

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.**

Hispanic:  Yes  No

Language:  English  Spanish  Creole  
 Other (Specify) \_\_\_\_\_

Country of Birth:  USA  Other (Specify) \_\_\_\_\_

Were you a single birth?  Yes  No

If NO, are you a:

Twin  Triplets  Other \_\_\_\_\_

Were you born

First  Second  Other \_\_\_\_\_

Living Address \_\_\_\_\_

Mailing Address \_\_\_\_\_

Alternate Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone# \_\_\_\_\_  Cell  Home

Phone# \_\_\_\_\_  Work  Fax

Alternate Phone# \_\_\_\_\_

### Part-2: Emergency Contact

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Phone# \_\_\_\_\_  Cell  Home  Work

### Part-3: Insurance Type

Medicaid  Medicare  HCD  Healthy Palm Beaches  None  Other

Policy # \_\_\_\_\_

Policy Holder \_\_\_\_\_

Date of Birth mm\_\_\_\_-dd\_\_\_\_-yyyy\_\_\_\_\_

### 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 pay stubs, 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) \_\_\_\_\_

Date of Birth: mm\_\_\_\_-dd\_\_\_\_-yyyy\_\_\_\_\_ Sex:  M  F

Employer's Name: \_\_\_\_\_

Monthly Gross Income: \_\_\_\_\_

Type of Income: \_\_\_\_\_

Monthly Child Care Expense: \_\_\_\_\_

Spouse's Name: (If different than patient) \_\_\_\_\_

Date of Birth: mm\_\_\_\_-dd\_\_\_\_-yyyy\_\_\_\_\_ Sex:  M  F

Employer's Name: \_\_\_\_\_

Monthly Gross Income: \_\_\_\_\_

Type of Income: \_\_\_\_\_

Monthly Child Care Expense: \_\_\_\_\_

### List all dependent family members:

Child #1 Name: \_\_\_\_\_

Date of Birth: mm\_\_\_\_-dd\_\_\_\_-yyyy\_\_\_\_\_ Sex:  M  F

Child #2 Name: \_\_\_\_\_

Date of Birth: mm\_\_\_\_-dd\_\_\_\_-yyyy\_\_\_\_\_ Sex:  M  F

Child #3 Name: \_\_\_\_\_

Date of Birth: mm\_\_\_\_-dd\_\_\_\_-yyyy\_\_\_\_\_ Sex:  M  F

Child #4 Name: \_\_\_\_\_

Date of Birth: mm\_\_\_\_-dd\_\_\_\_-yyyy\_\_\_\_\_ Sex:  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 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  Homeless Resource Ctr  Jupiter  Lantana/LW  Northeast  Pahokee-Glades  WPB