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 nan nesans (✓): □ Gason □ Fi	Ras: Tcheke ✓ tout kategori rasyal ki aplike: □ Nwa/Afriken/Ameriten □ Blan □ Ameriken Indien/Natif alasken □ Azyatik □ Natif natal Awayi/Lòt Abitan Zil Pasifik

Lang (✓): □ Angle □ Espayòl □ Kreyòl □ Lòt (Detay):	Nimewo Sosyal Sekirite:	Ispanic?: □ Wi □ Non
Eské'w té fêt pou kont ou? □ Wi □ Non Si non: □ Jimo □ Triplèt □ Lòt (Detay): Eské ou té fèt: □ Premye □ Dezyèm □ Lòt (Detay):	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

Èske ou vle resevwa KONFIDANSYÈL Kominikasyon Enfòmasyon sou Pwoteyete pa yon mwayen altènatif oswa adrès altènatif? □ Wi □ Non

Si ou vle pou nou diskite enfòmasyon medikal ou avèk yon lòt moun, kite ou mesaj postal ak rezilta tès yo ak /oswa konfimasyon randevou ou pral bezwen ranpli Fòm Konfidansyalite pasyan nou yo. **Èske ou vle ranpli Fòm Konfidansyalite Pasyan an?** □ Wi □ Non

Adres kote ou rete:	Apt#	Tcheke (√) yon sèl kòm kontak prensipal ou:
Vil:	State: FL Zip Kod:	□ Telefòn Selilè#
Adrès koté'w résévwa lèt si'l diféran dé koté'w rété a:	Apt#	□ Telefòn Lakay#
Vil:	State: FL Zip Kod:	□ Telefòn Travay#

Pati-2: KONTAK POU IJANS

Premye Non ou: Relasyon:

Siyati:

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

Clerical Use Only: No income or family size needed if Immunization only visit (√): □ VFC □ Adult

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) Eksepsyon se si w ap resevwa Sèvis pou Planifikasyon Familyal.

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/Paran		□ 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			$	$	$	$

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

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

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:_____ Date:_____

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

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Part-1: Client Information

Last Name	First Name	Middle Name	Suffix

Date of Birth: (mm/dd/yyyy)	Sex at birth (✓): ☐ Male ☐ Female	Race: Check (✓) all racial categories that apply: ☐ Black/African American ☐ White ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Language (✓): ☐ English ☐ Spanish ☐ Creole ☐ Other (Specify):	Social Security#:	Hispanic? ☐ Yes ☐ No
Were you a single birth? ☐ Yes ☐ No If NO, are you a: ☐ Twin ☐ Triplet ☐ Other (Specify): Were you born? ☐ First ☐ Second ☐ Other (Specify):	Country of Birth (✓): ☐ USA ☐ Other (Specify):	Date Arrived 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

Do you wish to receive CONFIDENTIAL Communications of Protected Health Information by an alternative means or alternate address? ☐ Yes ☐ No

If you wish for us to discuss your medical information with someone else, leave you voicemails with test results and/or appointment confirmations you will need to complete our Patient Confidentiality Form. **Do you want to complete the Patient Confidentiality Form?** ☐ Yes ☐ No

Living Address:	Apt#	Check (✓) One as your Primary Contact:
City: State: FL	Zip Code:	☐ Cell Phone#:
Mailing Address: (If different from where you live)	Apt#	☐ Home Phone#:
City: State: FL	Zip Code:	☐ Work Phone#:

Part-2: Emergency Contact

First Name: Relationship:

Last Name:

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

Clerical Use Only: No income or family size needed if Immunization only visit (√): ☐ VFC ☐ Adult

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) Exception is if you are receiving Family Planning Services.

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/PARENT		☐ 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			$	$	$	$

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

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

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