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)	Nimewo Sosyal Sekirite:	Sèks (✓): □ Gason □ Fi □ Change seks - Sèks nan nesans: □ Gason □ Fi
Adrès Email:	Peyi ou fet (✓): □ Etazini □ Lòt (Detay):	Dat nan Etazini:
Lang (✓): □ Angle □ Espayòl □ Kreyòl □ Lòt (Detay)	Tès pou Vwayajè:	Èske ou te vwayaje nan Afrik de Lwès nan 21 dènye jou ki sot pase yo? □ Yes □ No Èske ou te an kontak ak nenpòt moun ki te soti nan Afrik de Lwès nan 21 dènye jou ki sot pase yo?Yes □ No

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

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)

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#
Lot adres pou kominikasyion sou sante ou			Apt#	□ Nimewo Faks
Vil:	State: FL	Zip Kod:		□ Altène telefòn#

Pati-2: KONTAK POU IJANS

Premye Non ou:	Siyati:
Nimewo Telefon: □ Selilè □ Lakay □ Travay	Relasyon:

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 sèvi yo pap koute pou yon ti kraze ak pousantaj rabè ki baze sou gwosè fanmi ou ak lajan ou fè. Eksepsyon se si w ap resevwa Sèvis pou Planifikasyon Familyal.
(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: is 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: is 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 PEY 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)	Social Security#:	Gender (✓): □ Male □ Female □ Transgender-Gender at birth□ Male □ Female
Email:	Country of Birth (✓): □ USA □ Other (Specify):	Date to USA:
Language (✓): □ English □ Spanish □ Creole □ Other (Specify):	Travel Screen:	Have you travelled to West Africa in the last 21 days? □ Yes □ No Have you been in contact with any person who has been to West Africa in the last 21 days? □ Yes □ No

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

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):

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#:
Alternate Address for Health Care Communications:			Apt#	□ Fax Phone#:
City:	State: FL	Zip Code:		□ Alternate Phone#:

Part-2: Emergency Contact

First Name:	Last Name:
Phone # □ Cell □ Home □ Work	Relationship:

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 wil not be provided at a discounted rate based on the family size and income. Exception is if you are receiving Family Planning Services. (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:

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