Florida HEALTH Palm Beach County

DOH-PBC Registration/Eligibility Form

To be filed under eligibility

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):

Hispanic? ☐ Yes ☐ No

Social Security#:

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

Living Address: **Apt#**

City: **State:** FL **Zip Code:**

Mailing Address: (If different from where you live) **Apt#**

City: **State:** FL **Zip Code:**

Check (✓) One as your Primary Contact:
☐ Cell Phone#:
☐ Home Phone#:
☐ 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

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. 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/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