

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)		Social Security#:		Gender (✓): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender-Gender at birth <input type="checkbox"/> Male <input type="checkbox"/> Female	
Email:		Country of Birth (✓): <input type="checkbox"/> USA <input type="checkbox"/> Other (Specify):		Date to USA:	
Language (✓): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other (Specify):		Travel Screen: Have you travelled to West Africa in the last 21 days? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been in contact with any person who has been to West Africa in the last 21 days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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	
Race: Check (✓) <u>all</u> racial categories that apply: <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Guamanian or Charmorro <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Samoan					
Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, select one <input type="checkbox"/> Mexican or Mexican American or Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> 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):	
Living Address:				Apt#	Check (✓) <u>One</u> as your Primary Contact:
City:		State: FL	Zip Code:	<input type="checkbox"/> Cell Phone#:	
Mailing Address: (If different from where you live)				Apt#	<input type="checkbox"/> Home Phone#:
City:		State: FL	Zip Code:	<input type="checkbox"/> Work Phone#:	
Alternate Address for Health Care Communications:				Apt#	<input type="checkbox"/> Fax Phone#:
City:		State: FL	Zip Code:	<input type="checkbox"/> Alternate Phone#:	

Part-2: Emergency Contact

First Name:	Last Name:
Phone # <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> 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 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		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>			\$	\$	
SPOUSE		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>			\$	\$	
CHILD #1		<input type="checkbox"/> M <input type="checkbox"/> F			\$	\$	\$	\$
CHILD #2		<input type="checkbox"/> M <input type="checkbox"/> F		\$	\$	\$	\$	
CHILD #3		<input type="checkbox"/> M <input type="checkbox"/> F		\$	\$	\$	\$	
CHILD #4		<input type="checkbox"/> M <input type="checkbox"/> F		\$	\$	\$	\$	
CHILD #5		<input type="checkbox"/> M <input type="checkbox"/> F		\$	\$	\$	\$	
CHILD #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