



***** FOR OFFICE STAFF ONLY *****

<input type="checkbox"/> RQ	<input type="checkbox"/> NBRP	<input type="checkbox"/> FCHS
<input type="checkbox"/> AFM	<input type="checkbox"/> NBRD	<input type="checkbox"/> SWOC
<input type="checkbox"/> SWFM	<input type="checkbox"/> HHC	<input type="checkbox"/> OOC

MRN _____ SFS Patient Type _____

Part I: REGISTRATION

Please complete to the best of your knowledge. For areas that do not apply to the patient please enter "N/A".

Patient's Name <i>First MI Last</i>			DOB <i>MM/DD/YYYY</i> <input type="checkbox"/> Under 18?		
Mailing Address <i>Street</i>		<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>
Physical Address <i>Street</i> <input type="checkbox"/> Same as Mailing		<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>
Social Security # / Tax ID	Race/Ethnicity <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CONTACT INFORMATION

1st Phone ____ - ____ - ____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	2nd Phone ____ - ____ - ____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	3rd Phone ____ - ____ - ____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Emergency Contact: <i>Name</i>	<i>Relationship</i>	<i>Phone</i> ____ - ____ - ____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
How did you hear about us? <input type="checkbox"/> Family/ Friend <input type="checkbox"/> Hospital <input type="checkbox"/> Shelter <input type="checkbox"/> Media <input type="checkbox"/> Health Dept. <input type="checkbox"/> Social Services <input type="checkbox"/> Other _____		

INSURANCE/ GUARANTOR INFORMATION

Does the patient have Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please skip to part II.	Primary Insurance Carrier	Secondary Insurance Carrier
Total Household Size (<i>Reported For Tax Purposes</i>)	Total Household Income _____/ Year	
Guarantor's Name <input type="checkbox"/> Same as Patient <i>First MI Last</i>		DOB <i>MM/DD/YYYY</i>
Social Security # / Tax ID	Relationship	Phone ____ - ____ - ____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work

Have you been seen by any health care provider in the last 12 months, including the ER, Health Department, Urgent Care, or a private doctor's office?
 Yes No If YES where? _____

Release and Authorization/ Signature on File Statement

I hereby request, authorize and consent to medical care, including diagnostic procedures, HIV testing, and medical treatments as appropriate related to the health problem(s) for which I have sought services from Wake Health Services, Inc. (Wake Health). I authorize Wake Health to release information about me to my insurance company/companies, Medicare or Medicaid as appropriate. I request payment of medical insurance benefits related to these visits be paid directly to Wake Health. I understand that I am responsible for payment in full for any of my bills or services not paid by insurance.

Patient/Guarantor/Guardian Print

Patient/Guarantor/Guardian Signature

____/____/____
Date

Part II: MEQ and ELIGIBILITY QUESTIONNAIRE

- 1- Are you a full-time student? Yes No If yes, are you claimed as a dependent on a relative's taxes? Yes No
- 2- Have you applied for Medicaid or had Medicaid coverage in the past year? Yes No

Single Adults-Answer the Questions Below

- 3- Are you a US Citizen, refugee or lawful permanent resident admitted at least five years ago?
 Yes- Go to question 3 No- Go to Part III
- 4- Are you age 65 or older?
 Yes- Apply for Medicaid No- Go to question 4
- 5- Are you receiving Social Security Disability? Have you been or will you be disabled for 12 months? Are you legally blind?
 Yes-Apply for Medicaid No- Go to Part III

Family and Children- Answer the Questions Below

- 3- Are you under age 19, pregnant, OR the primary caretaker of a child living your home is under the age of 19?
 Yes- Go to question 2 No- Go to question 3
- 4- Are you a US citizen, refugee, or lawful permanent resident admitted at least 5 years ago?
 Yes- Apply for Medicaid No- Go to question 4
- 5- Have you had an emergency medical service (life threatening) within the past 3 months?
 Yes- Apply for Emergency Medicaid No- Go to Part III

Part III: SLIDING FEE APPLICATION

Please complete the form, answer ALL questions and submit ALL applicable documents from the check list below. When complete, please sign the bottom of the page. Incomplete applications (including lack of documents) will not be processed.

Required Supporting Documents for Sliding Fee Scale Application (Please Check All That Apply)		
<input type="checkbox"/> Photo I.D for patient and ALL adults claimed as dependents <input type="checkbox"/> Birth certificate, social security card, insurance card, or School I.D. for all dependents claimed under 18 <input type="checkbox"/> Pay check stubs showing GROSS amount for past 30 days for patient and all working claimed dependants, or letter from employer <input type="checkbox"/> Current tax returns if (1) self employed (2) claiming an adult as a dependent (3) applying for drug assistance or (4) receive dividends or profit from stock	<input type="checkbox"/> Proof of Unemployment For letter, call Employment Securities Commission 1-888-737-0259. <input type="checkbox"/> Social Security Income - early retirement, retirement, or disability. For letter, call Social Security Admin - 1-800-772-1213. <input type="checkbox"/> Proof of pension <input type="checkbox"/> Proof of child support and/or alimony For letter, call court where ordered <input type="checkbox"/> Proof of county residence	
HOUSEHOLD		
<i>Please list family members who live in your household and are claimed as dependants for tax purposes:</i>		Total Household Size: _____
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN
Name	DOB	SSN/TIN

*** If you will be applying for the Drug Assistance Program (DAP) you will be asked to provide your most recent tax forms to the pharmaceutical companies to qualify for the program***

I HEREBY CERTIFY THAT I LIVE IN THE STATE OF NORTH CAROLINA, AND THE INFORMATION SUBMITTED IS TRUE TO THE BEST OF MY KNOWLEDGE. I also give permission to Wake Health Services, Inc to contact any individual that may have information regarding my eligibility. I declare, under penalty of perjury, that the information on this form, my Federal Income Tax Return, and my accompanying schedules submitted with this application to Wake Health Services are true, correct and complete. If it is determined that any of the information provided is not accurate or I fail to immediately notify Wake Health Service of any changes, I understand that I will be removed from the SFS program and all charges will be reinstated. I also agree to pay the determined co-pay at the time of my medical or dental visits. I understand that failure to pay the co-pay at the time of service will result in my removal from the SFS program.

_____ /_____/_____
 Patient/Guarantor/Guardian Print Patient/Guarantor/Guardian Signature Date