South Central Missouri Community Health Center
DBA Your Community Health Center
1081 East 18th Street
Rolla, MO 65401
573.426.4455

We have exciting news regarding your health care!

We are proud to announce that YCHC now offers you the opportunity to use the power of the web to track all aspects of your health care through our office. The Patient Portal provides our patients the opportunity to communicate with our practice easily and safely via the Internet.

Once you register, you will have electronic access to our practice and be able to:

- Email our office
- Request an appointment
- Request medication renewals
- Access your medical records

Patient Portal Sign-up Instructions
Complete the following steps to connect with us online:

1. You will need to provide our office with a permanent email address.
2. After your email address is provided, we will send you a message with your username and password information.
3. Visit the website at https://mycw91.ecwcloud.com/portal12226/jsp/100mp/login_otp.jsp and use the information in the email provided to log in.

You can also download the Healow App on your Android or Apple device.

The portal is a secure and convenient place to manage your health records and those of your family members as well.

If you have questions or need assistance with the patient portal or the Healow App, please contact Kassy Troutt at 573-426-4455.

Begin taking an active role in managing your health care today!

Thank you,
Your Community Health Center
www.your-chc.org

Newburg School Based Clinic Packet

In order to provide health services for your child we need the following information:

Patient's Name: ______________________________ Patient Date of Birth: __________ Grade: ________

Parent/Guardian Name: ______________________________ Parent/Guardian's Date of Birth: __________

Relationship to Child: ______________ Parent/Guardian's Social Security No: ____________________

Address: ____

Home Phone: ____________________ Cell Phone: ______________ Work Phone: ______________

Emergency Contact Person: ______________________________ Phone Number: ______________

Regular Primary Care Provider or Clinic: ____________________ Phone Number: ________________

Date of last complete yearly physical examination (head to toe): ______________________________

Regular Dentist/Clinic: ______________________________ Phone #: ____________________

Date of last routine dental check-up: __________ Date of last complete yearly eye exam: ______________

Do you want a copy of the physical exam to go to your clinic or doctor? (check one) Yes_____ No_____

Preferred Pharmacy: ______________________________ Pharmacy Phone: ______________

Health Insurance Information

<u>IMPORTANT:</u> Please **ATTACH** a copy of ***your Medicaid, MO Health Net for Kids or Private Insurance*** card to this parental consent form. We will only bill insurance with Parental/Guardian's Consent – no children will be charged directly for services. All third-party payment sources and co-payments will be billed.

PLEASE CHECK ONE:

- ○ Medicaid
- ○ MO Health Net for Kids
- ○ Private Insurance
- ○ No Insurance

  (IF I HAVE CHOSEN NO INSURANCE - MY CHILD HAS NO TYPE OF HEALTH INSURANCE)

Health Insurance Plan ______________

Name of Insured (policy holder) __________

Policy #. ____________________

Policy Holder DOB: ______________

X____

Signature of Parent/Guardian

Your Community HEALTH CENTER

YCHC Newburg School Health History Form

PATIENT NAME________________________________ **DATE OF BIRTH:** ______________________

1. **Is your child allergic to any medications?**

   No__________ Yes__________If yes, please list: ______________________________________

2. **Any severe food allergies?** Please list ______________________________________

   Any other allergies? Please list ______________________________________

3. **Does your child or any family member have or had any of these problems? (Please Check)**

	Child | Family		Child | Family		Child | Family
Asthma or wheezing	____ ____	Fainting with exercise	________	Nightmares	______
Allergies/hay fever	____ ____	Frequent Headaches	________	Rheumatic Fever	______
ADHD / ADD	____ ____	Frequent Sore Throats	________	Seizure Disorder	______
Anemia / blood problems	____ ____	Frequent Stomach Aches	________	Sickle Cell problems	______
Anaphylactic reaction	____ ____	High Cholesterol	____ ____	Sinus Trouble	____ ____
Abnormal spinal curvature	____ ____	Heart Murmur	____ ____	Sleep Problems	____ ____
Alcohol / Drug Abuse	____ ____	Hearing Loss/Problems	____ ____	Snoring	____ ____
Acne	____ ____	Heart Disease	____ ____	Speech Problems	____ ____
Behavior problems	____ ____	High Blood Pressure	____ ____	Stomach Ulcers	____ ____
Boys: testicle not in sac	____ ____	HIV / Aids	____ ____	Suicide	____ ____
Bowel Movement in pants	____ ____	Hives	____ ____	Stroke	____ ____
Bleeding Disorders	____ ____	Hyperactivity	________	Toothache/Dental problems	____ ____
Broken bones	____ ____	Joint problems	____ ____	Tuberculosis	____ ____
Cancer – type	____ ____	Kidney Disease/Problems	____ ____	Underweight	____ ____
Chicken pox	____ ____	Lead Poisoning	____ ____	Urinary Tract Infections	____ ____
Diarrhea/ constipation	____ ____	Learning Problems	____ ____	Eye lid Twitching	____ ____
Chronic ear infections	____ ____	Leukemia	____ ____	Eye Burning	____ ____
Concussion	____ ____	Lumps in groin/breast	____ ____	Double Vision	____ ____
Depression	____ ____	Mental Illness	____ ____	Dry Eye	____ ____
Diabetes	____ ____	Migraines	____ ____	Eye Strain	____ ____
Dizziness / Lightheaded	____ ____	Muscle Problems	____ ____	Itchy Eyes	____ ____
Eczema / skin infections	____ ____	Nervous twitches/Tics	____ ____	Watery Eyes	____ ____
Vaginal Discharge	____ ____	Nosebleed	____ ____	Light Sensitivity	____ ____

Ethnicity		Education		Employment Status
☐ Hispanic or Latino		☐ Current Student?		☐ Full Time/ Part Time
☐ Not Hispanic		☐ Full Time		☐ Migrant Worker
☐ Unreported /Refused to Report Ethnicity		☐ Part Time		☐ Not a Migrant Worker
		☐		☐ Seasonal

Race		Highest Level of Education		Housing
☐ Asian		☐ Not yet in school		☐Homeless
☐ Native Hawaiian		☐ Pre-School Kindergarten		☐Doubling Up ☐Shelter ☐Other ☐Street ☐Transitional ☐Unknown
☐ Other Pacific Islander		☐ Grade School		
☐ Black/African American		☐ Middle School		
☐ American Indian/ Alaska Native		☐ High School		
☐ White (not Hispanic or Latino)		☐ High School Degree/ GED		☐Public Housing-HUD
☐ More than one race		☐ Did not complete High School		
☐ Not Reported / Refuse to Report		☐ Technical Trade School		

Primary Language				Are you a veteran?
☐ English		☐ College		☐ Yes
☐ Spanish		☐ College Graduate		☐ No
☐ Russian				
☐ Ukrainian				
☐ Other Please Specify:				

How did you hear about us?		YCHC is my primary medical home?		Patient Self Determination Act
				I have an advance directive?
☐ Newspaper/TV/Radio Ad		☐ Yes		☐ Yes
☐ Website		☐ No		☐ No
☐ Special Event		☐		
☐ Employee		I am using YCHC today for an urgent care need?		
☐ Other Organization		☐ Yes		
☐ Friend		☐ No		
☐ Other				

PERSON(S) WHO MAY ACCOMPANY MINOR & MAKE DECISIONS FOR MEDICAL/DENTAL/ BEHAVIORAL TREATMENT

Name:	Relationship:	Phone:
1.		
2.		
3.		

PERSON(S) WHO MAY OBTAIN MY HEALTH INFORMATION FROM YCHC

Name:	Relationship:	Phone:
1.		
2.		

PATIENT NAME________________________________DATE OF BIRTH: ____________________

Medical History

Please circle yes or no below, and explain any yes answers on the line provided:

Does your child CURRENTLY take any medications?	YES	NO	____________________
Has your child taken any medication(s) in the past?	YES	NO	____________________
Has your child ever been pregnant?	YES	NO	How many living children has your child given birth to?________
Has your child ever been in the hospital overnight?	YES	NO	____________________
Has the child had any surgery(ies)?	YES	NO	____________________
Has your child had any head injury(ies)?	YES	NO	____________________
Does your child have any developmental delays?	YES	NO	____________________

Dental History

Please circle yes or no below, and explain any yes answers on the line provided:

Does your child have any dental pain?	YES	NO	____________________
Does your child brush their teeth?	YES	NO	____________________
Does your child floss?	YES	NO	____________________
Has your child received fluoride treatments?	YES	NO	____________________
Has anyone explained the importance of primary teeth to your child?	YES	NO	

Student's History

Please circle yes or no below, and explain any yes answers on the line provided:

Has anyone had a heart attack before age 50?	YES	NO	____________________
Is there a gun in the home?	YES	NO	____________________
Does anyone at the child's home smoke?	YES	NO	____________________
Has your child been a victim of abuse?	YES	NO	____________________
Has your child seen someone be abused?	YES	NO	____________________
Is your child been a victim of bullying?	YES	NO	____________________

What Activities/Hobbies does your student have:

____

____

____

Acknowledgement of Receipt of Privacy Practices

PATIENT NAME________________________________**DATE OF BIRTH:** ____________________

We are required to give each patient a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. By signing this form, you acknowledge receipt of this notice and a copy of our patient brochure. You may refuse to sign if you wish.

Please answer the following questions so that we can contact you in the most e cient way possible.

If you have an answering machine at home, may we leave a message? Yes

No

May we leave a message at your work for you to call our office? Yes

No

May we e-mail you? Yes No

Is there a person at your house that we may leave a message with? Yes

No

May we provide visit information to the school nurse, in case we can't reach you? Yes

No

List below any person/persons authorized by you to discuss/receive your medical information:

____
Name/address/phone/relationship

____
Name/address/phone/relationship

Newburg R-II School YCHC

Clinic-Parent Consent Form

* Students who are over 18 years of age may consent for their own services. Certain other services may be available to minors (children – less than 18 years old) without parental consent.

PATIENT NAME__________________________________DATE OF BIRTH: ___________________

I/we have read and understand the services offered at the Your Community Health Center Newburg Clinic as described below. I/We understand further that the services authorized by my/our signature on this form are simple, common or routine health care services, and treatment will be limited to:

• Diagnosis and treatment of minor and acute illnesses.	• Assistance with chronic (ongoing) illnesses, such as asthma and diabetes. *Some diagnostic tests may not be performed at SBHC.	• Prescribed medications can be sent to pharmacy of choice. Immunizations/vaccinations will be scheduled at the SBHC once monthly.
• First Aid of minor injuries.	• Pregnancy testing and referral for prenatal care.	• Limited laboratory services.
• Physical examinations (General sports, pre-employment).	• Treatment of acne and other skin problems.	• Referrals for alcohol and/or other drug abuse issues.
• Diagnosis and treatment of sexually transmitted diseases. *Some diagnostic testing and treatment may not be performed at the SBCH.	• Family planning services, including noninvasive examinations and oral or barrier contraceptive methods.	• Referrals for health services which cannot be provided at the Your Community Health Center Newburg Clinic.

I have listed below those services, which I DO NOT want my student to receive at the Your Community Health Center Newburg Clinic:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Newburg R-II School YCHC Clinic-Parent Consent Form

I/We understand that this consent covers only those services provided at the Your Community Health Center Newburg Clinic or another Your Community Health Center clinic that result from a request from the parent/guardian or student, or from a referral made by school personnel to the Your Community Health Center Newburg Clinic, and does not authorize services rendered by or at any other private or public facility.

I/We understand that the Your Community Health Center Newburg Clinic is not a part of the regular and ongoing program of the Newburg R-II School District, and the services provided are not school-sponsored activities or programs. The services are made available at the school /site for my convenienceto obtain health services for my child. I/We understandthat the Newburg School District does not assume responsibility for the services provided by the Your Community Health Center Newburg Clinic.

I/We hereby authorize a physician, nurse practitioner or other professional clinic staff to provide necessary and/or advisable treatment for my son/daughter. This student has my/our permission to receive all services offered at the Your Community Health Center Newburg Clinic EXCEPT those that I have specifically excluded above.

I/WE understand that I can revoke this consent at any time by submitting a request in writing to the Your Community Health Center Newburg Clinic.

I/We understandd THAT NO STUDENT WILL BE CHARGED DIRECTLY FOR SERVICES. All third-party payment sources accessible to the student will be billed.

Medical Records will be kept in a secure and confidential manner, however, I/We acknowledge that the Your Community Health Center Newburg Clinic may release information regarding treatment to third-party payers, such as MO HealthNet or insurance companies for the purpose of billing. I/We also understand that public information such as immunization history or illness that constitutes a public health hazard may be shared with the school nurse, or the public health department to protect the health of other students and the public.

I/We understand that this consent is good for one year (12 months) from the date of the signature below.

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE
RELATIONSHIP TO STUDENT	
ADDRESS OF PARENT/LEGAL GUARDIAN (IF DIFFERENT FROM ABOVE)	
TELEPHONE	
OFFICE USE ONLY	
SIGNATURE VERIFIED BY	DATE

THE FOLLOWING PAGES

ARE FOR YOU TO REVIEW

AND KEEP FOR YOUR

RECORDS

Program Description
YCHC Newburg School-Based Health Center

Welcome to Your Community Health Center's School-Based Health Center (SBHC). The SBHC can provide medical care to all students and staff of Newburg R-11. If your child becomes sick at school, needs a routine, employment or sports physical or immunizations the SBHC can provide these services while limiting your child's missed school time.

How the School-Based Health Center (SBHC) works:

- You must complete the attached forms to include the **parental consent**. These forms must be returned to the school office before your child can be seen at the SBHC.
- You or your child may schedule an appointment in the SBHC if your child is sick or injured.
- You can also schedule routine appointments for all other health care concerns.
- Any necessary prescriptions will be sent to your pharmacy. Orders or referrals will be provided for diagnostic testing or treatments that cannot be performed at the SBHC but are necessary for care and diagnosis.
- Before and after your child's visit with the provider attempts will be made to contact you as necessary. .
- **The School-Based Health Center does not take the place of your primary care provider (PCP) and joining the program does not mean you are changing your child's PCP.** You will be encouraged to have any needed follow-up care with your PCP and a summary of your child's visit will be sent to that office. However, if you do not have a regular PCP, we welcome that relationship here and you can use the SBHC provider at any of our clinic locations. Even if your child has already been seen at any of the Your Community Health Center locations, you are still required to sign the consent to receive care at the SBHC.

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow at least 30 days for completion of insurance or disability forms and transfer of treatment records.
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with our nurse line, please call *855.581.7930.*

The PRIMARY HEALTH CARE SERVICES will include:

- Visits for minor and acute illnesses (for example, sore throat, rash, or asthma attack) and follow-up for medical problems, including physical examination, tests and treatment/medications as needed.
- Minor injury evaluation, including first aid that is beyond the scope of the school nurse.
- Routine physical examination (including sports and work physicals) with immunizations, routine tests and treatments as needed.
- Management of chronic conditions such as hypertension, diabetes, and high cholesterol (some diagnostic and follow up testing services may not be performed at the SBHC).
- Health education and wellness promotion.
- Referral to outside agencies for further care that cannot be provided at the SBHC.

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **Sliding Scale Fee.** However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on Your Community Health Center's (YCHC) sliding fee scale. This information will be kept strictly confidential.
- If you have private insurance, you should contact their customer service department to be sure your insurance pays for services at YCHC. If your insurance does not cover YCHC, you will be responsible for the bill at the appropriate discounted fee based on your household income.

- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid, you can stop by our center or call 573-426-6711.

Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's PCP.
- **Your Community Health Center's School-Based Health Center and/or the Newburg R-II Schools' nurses will share medical information, including immunization records, with each other as needed.**
- The child's medical and any other information will only be used in the treatment, payment and health care operations of the School-Based Health Center. All of your child's information will be kept strictly confidential according to all state and federal laws.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, School-Based Health Center or Your Community Health Center may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Your Community Health Center's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Your Community Health Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Your Community Health Center, PO Box 458, Rolla, MO 65402.

With my consent, School-Based Health Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, School-Based Health Center or Your Community Health Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that School-Based Health Center or Your Community Health Center restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to School-Based Health Center's uses and disclosure of my Protected Health Information to carry out treatment, payment and operation.

- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the School-Based Health Center may decline to provide treatment to me.

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*Please note that the School-Based Health Center is **completely optional.** School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Center or not.

This consent will remain in effect until your child is no longer enrolled in Newburg R-II Schools. You may revoke this consent for treatment at any time by requesting the School-Based Health Center, in writing, to have your child removed from School-Based Health Center. Please notify us at the number below and in writing for any changes in guardianship.

Please keep this Program Description for your records.

The School-Based Health Center is an excellent way to keep your child healthy and in school. Please let us know if there is anything keeping you from enrolling your child. If you have any questions or need help with the application, please call Your Community Health Center at (573)426-6711 or contact your school nurse.

(Rev. 10/16)
HIPAA Privacy Notice

To make an appointment please call 426-4455

Comprehensive on-site health care for all Newburg R-II Students and Employees

What services may be offered?

- Care of chronic conditions such as asthma, diabetes, and depression
- Care for acute illness-fever, sore throat, stomach pain
- Care for common concerns such as acne, menstruation, weight issues
- Testing and treatment for sexually transmitted illnesses
- School, sports, camp, and employment physical exams
- Immunizations
- Prescriptions and medications ordered
- Lab work (blood draws)
- School based counseling (time management, coping, grief, bullying)

What services are not included?

- X-rays
- Vision care
- Dental are

School-based health center hours?

- Monday 7:30 a.m. to 4:30 p.m. and Thursday from 7:30 a.m. to 11:30 a.m. when school is in session

Who provides the services?

- Nurse Practitioner/Physician
- LCSW
- Medical Assistant
- Pharmacist

Parent Involvement?

A parent or guardian must sign a consent form before their child may use any health center service. Once this is done, the child may use the health center at any time during the school year consent period.

Supporting family communications is a principal goal of the health center. We also urge you to consider to become part of the community/parent advisory board that will be meeting in November and April each year.

Confidentiality?

Visits to the health center are confidential. Information is not shared without patient and/or parental permission. The only exception is a life-threatening situation.

What does it cost?

For students on Medicaid (MO Health Net for Kids) there is no cost. Other students and Newburg employees may use their private insurance and/or use our sliding fee payment (based on family size and income).

Insurance enrollment help?

Insurance outreach and enrollment staff are available to assist families with the insurance enrollment process

YCHC respects the right of our patients, if you would like a printed copy of YCHC Right and Responsibilities please contact us at 573-426-4455 or copies are available on our website your-chc.org

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Family Size and Income

This is important information for our federal funding

Patient Name: ______________________________

Instructions: Please select the **family size** in the far left column. Then **please circle** your **income range** to the right of your selected family size (in the same row.)

# Persons in Household	Household Income	100%		101%-125%		126%-150%		151%-200%		Over 200%	
Visit Fee		**$20.00**		**$30.00**		**$40.00**		**$50.00**		**Full Pay**	
	Annual	0 -	12,140	12,141	15,175	15,176	18,210	18,211	24,280	24,281	+
1	per month	0 -	1,012	1,013	1,265	1,277	1,518	1,519	2,024	2,025	+
	per week	0 -	233	234	291	292	438	439	466	467	
	Annual	0 -	16,460	16,461	20,575	20,576	24,690	24,691	32,920	32,921	+
2	per month	0 -	1,372	1,373	1,715	1,716	2,058	2,059	2,744	2,745	+
	per week	0 -	317	318	396	397	475	476	634	635	+
	Annual	0 -	20,780	20,781	25,975	25,976	31,170	31,170	41,400	41,401	+
3	per month	0 -	1,732	1,733	2,165	2,166	2,598	2,599	3,464	3,465	+
	per week	0 -	400	401	500	501	600	601	800	801	+
	Annual	0 -	25,100	25,101	31,375	31,376	37,650	37,651	50,200	50,201	+
4	per month	0 -	2,092	2,093	2,615	2,616	3,138	3,139	4,184	4,185	+
	per week	0 -	483	484	603	604	724	725	966	967	+
	Annual	0 -	29,420	29,420	36,775	36,776	44,130	44,131	58,840	58,841	+
5	per month	0 -	2,452	2,453	3,065	3,066	3,678	3,679	4,904	4,905	+
	per week	0 -	566	567	707	708	849	850	1,132	1,133	+
	Annual	0 -	33,740	33,741	42,175	42,176	50,610	50,611	67,480	67,481	+
6	per month	0 -	2,812	2,813	3,515	3,516	4,218	4,219	5,624	5,625	+
	per week	0 -	649	650	811	812	973	974	1,298	1,299	+
	Annual	0 -	38,060	38,061	47,575	47,576	57,090	57,091	76,120	76,121	+
7	per month	0 -	3,172	3,173	3,965	3,966	4,758	4,759	6,344	6,345	+
	per week	0 -	732	733	915	916	1,098	1,099	1,464	1,465	+
	Annual	0 -	42,380	42,381	52,975	52,976	63,570	63,571	84,760	84,761	+
8	per month	0 -	3,532	3,533	4,415	4,416	5,298	5,299	7,064	7,065	+
	per week	0 -	815	816	1,018	1,019	1,222	1,223	1,630	1,631	+

Dental	100%	Class1	**Nominal Fee $50.00 ***
	101-125%	Class 2	**$60.00 copay or 35% of charges**
	126-150%	Class 3	**$70.00 copay or 45% of charges**
	151-200%	Class 4	**$80.00 copay or 55% of charges**

*** Any laboratory fees listed on 2017 Laboratories Fees Schedule that was incurred at the time of service for patients in Dental Class I will be charged to the patient in addition to their sliding fee charge.**

Sliding Fee Information

Thank you for selecting Your Community Health Center. Part of our mission for YCHC is to provide quality services to you and your family. In doing so, YCHC offers a sliding fee adjustment for patients and members of their families (as defined below) who fall below 200% of the poverty guidelines as set forth by the Federal Government. Income levels are based on total "family" income, family is defined below. The amount of the discount and the income ranges for those discounts are set by YCHC's Board of Directors and approved by the Federal Government. Income guidelines are revised annually. Current discounts and income guidelines are available at Your Community Health Center.

The sliding fee application will cover all medically necessary medical, behavioral, and dental services. The costs of procedures, labs, tests, and provider visits that are deemed medically necessary will qualify for the sliding fee discount. The costs of procedures, labs, tests and provider visits that are deemed optional, cosmetic or experimental will be the responsibility of the patient requesting the services at 100% of the regular rate charged. Even if services are ordered by a provider, it does not necessarily mean that they are medically necessary.

<u>**Definitions**</u>

Family-A family means those persons within the same household (including dependents/partner) who are applying for the sliding fee discount using their combined income.

Individual-An individual is a person 18 years old or over who has verifiable income using the list below (*).

<u>**Income Verification**</u>

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify YCHC of that change. YCHC reserves the right to verify income with an employer at any time. (*)
Patients are required to provide at least two of the following items as verification of income.

- Previous year tax return
- Previous year W-2 form(s)
- Current pay stubs (last 4 weeks, if possible)
- Lay-off notification from last employer
- Current information from unemployment office
- Denied Medicaid application and reason for denial)
- Pay Stubs from unemployment (last 4, if possible)

(Continued on next page)

If you were not required to file prior's years income tax return or you receive any of the following types of income, documentation must be submitted showing the amounts of each received by any member of the household.

- Child Support
- Food Stamps
- Welfare Assistance
- Social Security
- Unemployment
- Self-Employment Income
- Alimony
- Retirement Income
- Worker's Compensation
- Disability Income
- Any Other Income

Eligible Fees

Medical, Mental Health and Dental Services that are provided at YCHC are eligible for the sliding fee discounts. **Previous charges, OWI assessments, elective procedures and outside services are not eligible for a sliding fee discount. Deductibles are eligible for sliding fee discounts.**

Minimum Charge

There is a minimum medical, mental health and dental charge for all sliding fee visits, as approved by the YCHC Board of Directors Payment is expected at time of service. If you are unable to pay for your appointment today, please let the front desk staff know so payment arrangements can be made.

Additional Information

Timeliness in completing the sliding fee application is important. You have 14 days to return the required income verification documentation. If you do not submit the required documentation, your application for the sliding fee will not be approved. If you are unable to provide the information, please let YCHC staff know so they can assist you. Thank you!!

Please note that all patients, regardless of sliding fee requests, are asked to complete income information as it is necessary for continued clinic funding.

Sliding Fee Application

Patient's Name:____

Home Address: ____

City: ________________ State: ______ County:__________Zip: __________

Sex: Female Male Date of Birth: ________

Home Phone: ____________ Work Phone: ____________

Employer/School:________________________Occupation: ____________

Employer's Address: ____________________________________

Is your employment seasonal? Yes No

Is your employment related to agriculture? Yes No

Number of people in your household? ________

Annual Gross Income (all adult members of household)? $________________

Financially Responsible Party:

Name:__________________________________Date of Birth: ________

Relationship to Patient:____________________

Home Address: ____

City:______________State:_____Zip: __________

Home Phone: ____________________ Cell Phone:____________________

Family Size: (If additional space is needed, please add to back of page)

Name	Date of Birth	Relationship

Income:

	Current Monthly	Last 12 Months Total
Wages or Self Employment	$ ____________	$ ________________
Social Security/Public Assistance	$ _____________	$ __________________
Unemployment/Workers Comp	$ _____________	$ __________________
Alimony/Child Support	$ _____________	$ __________________
Pensions/Retirement Income	$ _____________	$__________________
Food Stamps/Welfare Assistance	$ _____________	$ _________________
Disability Income	$ _____________	$ __________________
Any Other Income	$ _____________	$ __________________

I declare under penalty of perjury, under laws of the State of Missouri, that all statements contained in this application and accompanying documents is true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial of application.

I have read the Sliding Fee Application and I understand that payment is due at the time of services. If documentation of income verification is not given to YCHC within 30 days of this application, the application will no longer be valid and you must reapply. Thank you in advance for your cooperation.

Signature: ____ Date: _________________________