Genesis Health Care

# New Patient Questionnaire

## PATIENT INFORMATION

**Full Name:** _____

**Current Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Home Phone:** _____ **Mobile:** _____

**Gender:** ☐ Male ☐ Female ☐ _____ **DOB:** _____ **Age:** _____

1. What type of Medical Insurance do you currently have?

2. What medical problems are you experiencing? (We do not provide Chronic Pain Management Services)

3. Have you been diagnosed with any chronic medical conditions (Diabetes, Hypertension, Arthritis, Depression, GE Reflux, Etc.)? Please list these conditions below:

4. Are you currently taking (or supposed to be taking) any medications? Please list these medications below:

5. What Pharmacy do you currently use (Name and City)?

6. Do you currently have a Primary Care Provider? If so, what is his/her name and their phone number? When was the last time you were seen by your Primary Care Provider?

7. Is there a specific provider you would like to see at our practice? Please keep in mind that we will try to place you with the provider of your choice, but we may not be able to if the provider does not have new patient appointments available.

8. Are you interested in serving on the Board of Directors for Genesis Health Care Inc.?

**MEDICAL STAFF: Before scheduling any new patient, it is your responsibility to research the system for any previous existing chart for the patient. You may do this by first searching by date of birth, patient name and patient social security number. If there is a duplicate, OPEN THE CHART AND USE THE PATIENT'S OLD CHART NUMBER. DO NOT CREATE A NEW CHART.**

Genesis Health Care

# New Patient Application

**Welcome to our office. Please complete the following information.**

## PATIENT INFORMATION

| Last Name | First Name | M.I. | Social Security # |
|---|---|---|---|
| | | | |

Address

| Home Telephone | Cell Phone | Date of Birth | Age |
|---|---|---|---|
| | | | |

Email

☐ Yes! Sign me up for Genesis email updates.

## Please Check All That Apply

**Gender:** ☐ Male ☐ Female ☐ Female-to-Male/Transgender Male ☐ Male-to-Female/Transgender Female ☐ Genderqueer/Neither Male nor Female

**Sexual Orientation:** ☐ Bisexual ☐ Lesbian/Gay/Homosexual ☐ Straight/Heterosexual ☐ Unknown ☐ Asexual/Other ☐ Rather Not Disclose

**Insured's Language :** ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ German ☐ Italian ☐ Sign Language ☐ Other

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner ☐ Unknown

**Race :** ☐ African-American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian ☐ White ☐ Pacific Islander ☐ Other ☐ Rather Not Disclose

**Ethnicity:** ☐ Hispanic/Latino ☐ Other

**Veteran Status:** ☐ Yes ☐ No ☐ Unknown

**Employment Status:** ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Disabled ☐ Military ☐ Self-Employed ☐ Unemployed

| Employer | Work Telephone |
|---|---|
| | |

**Student?:** ☐ Yes, Full-time Student ☐ Yes, Part-time Student ☐ No

If yes, provide school name: _____

**Place of Birth:** City _____ State _____ Country _____

**Agricultural Status:** ☐ Migrant Worker ☐ Seasonal Worker ☐ Non Agricultural Worker ☐ Dependent of Migrant Worker ☐ Dependent of Seasonal Worker

**Housing Status:** ☐ Doubling up ☐ Homeless Shelter ☐ Not Homeless ☐ Public Housing ☐ Street ☐ Transitional ☐ Unknown

| | | |
|---|---|---|
| **Olanta Family Care**<br>**211 S Jones Rd**<br>**Olanta, SC 29114**<br>**Telephone (843) 396-9730**<br>**Fax (843) 396-9735** |  | **Pee Dee Healthcare**<br>**201 Cashua St**<br>**Darlington, SC 29532**<br>**Telephone (843) 393-7452**<br>**Fax (843) 393-6210** |
| **Lamar Family Care**<br>**301 W Main St**<br>**Lamar, SC 29069**<br>**Telephone (843) 395-8400**<br>**Fas (843) 395-8401** | **Walterboro Family Care**<br>**457 Spruce St.**<br>**Walterboro SC, 29488**<br>**Telephone (843) 781-7428**<br>**Fax (843) 781-7429** | **Dr. Brent Baroody OB/GYN**<br>**1523 Heritage Ln #A**<br>**Florence SC, 29505**<br>**Telephone (843) 673-9992**<br>**Fax (843) 673-9996** |


I_____ acknowledge that it has been explained to me that Genesis Healthcare, Inc. does not provide chronic narcotic pain management. This includes the use of narcotic medication as well as other supplemental controlled substances. I understand and agree that I will be referred to another clinic for pain management by that facility's physician.

_____ _____

Patient Signature Date

_____ _____

Signature of GHC Staff Member Date

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# PATIENT INFORMATION

**REFERRAL SOURCE**

Name: _____ City: _____ State: _____

**PRIMARY CARE PHYSICIAN**

Name: _____ City: _____ State: _____

**PHARMACY**

Name: _____ City: _____ State: _____

## INSURANCE

| | | |
|---|---|---|
| Insured's Name (If other than patient): | | Insurance Company: |
| Address: | | |
| SSN: | DOB: | Employer: |
| Emergency Contact: | Relationship: | Phone: |

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## ANSWERING MACHINE MESSAGES

There may be times when our office is not able to reach you by telephone. With your permission, we would like to be able to leave messages on your home answering machine. In order to comply with strict legal standards, a written release will allow us to leave a message on your answering machine. By signing below you are authorizing us to leave messages on your answering machine at the telephone number you have given us in your record.

**Patient's Signature:** _____ **Date:** _____

## HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Some patients prefer that other individuals, especially family members, be allowed access to their medical information. In order to comply with strict legal standards, a written release is required to allow another person access to your medical records. This release grants permission to individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication.

**Patient's Signature:** _____ **Date:** _____

**1. Designated Party:** _____

**Telephone:** _____ **Relationship:** _____

## MEDICARE PATIENTS - LIFETIME AUTHORIZATION TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS, AND PATIENT

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician.

**Patient's Signature:** _____ **Date:** _____

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# CONSENT FOR TREATMENT AND AUTHORIZATION

I, the undersigned, do hereby authorize and consent to medical examinations, x-rays, blood tests, laboratory procedures, immunizations, therapeutic injections, invasive or surgical procedures and other medically appropriate services under the general or specific supervision of any member of the medical staff of Genesis Health Care, Inc for the patient named on this form.

It is understood that this authorization is given in advance of any specified diagnosis, treatment or care being required but it is given to provide authority and power to render care by providers of Genesis Health Care, Inc. in the exercise of her/his best judgment that they may deem advisable. I understand that state law requires physicians to report certain communicable diseases to the Health Department.

I agree that if I leave a physician's office against the advice of my physician(s) of Genesis Health Care, Inc and its personnel, they are released from responsibility or liability for any injuries or damages which may result from leaving against medical advice.

I authorize a physician of Genesis Health Care, Inc to test me for HIV antibodies or tuberculosis when the doctor or any employees are exposed to body fluids in a manner which may transmit human immunodeficiency virus (HIV), or infection of tuberculosis. In the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the person(s) who may have been exposed.

| Patient Name - Print | Patient/Authorized Person Signature | Date |
|---|---|---|

**Allergies:** _____

| List All Current Medication | List All Chronic Illnesses and Surgeries |
|---|---|
| | |
| | |
| | |
| | |
| | |

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**Patient's Name:** _____

## FINANCIAL STATEMENT

I understand and agree that regardless of my insurance coverage, I am ultimately responsible for payment of any charges for professional services rendered. I understand that I will be ultimately responsible for collection fees and any attorney fees should my account be placed with a collection agency due to nonpayment of my account. I certify that the information I have given is true and correct to the best of my knowledge. If I have health insurance, Genesis Health Care, Inc. will file on my behalf, but it is my responsibility to see that my health insurance policy pays the benefits provided under said policy. If there is a change in family member status, it is my responsibility to give the information, in writing, to Genesis Health Care, Inc. as I am responsible for all charges incurred for my family members.

I authorize Genesis Health Care, Inc to release any and all medical and billing information to any health care provider involved in my treatment and to any health care facility directly or indirectly involved in my treatment for purposes including, but not limited to, billing, collection, quality assurance or risk management activities, or defense of litigation or anticipated litigation and to any insurance company, health maintenance organization or other entity which is directly or indirectly responsible for payment or review of services provided by Genesis Health Care, Inc. I request that payment for professional service rendered be made directly to Genesis Health Care, Inc. I permit a copy to be used in place of the original.

**Patient's Signature:** _____ **Date:** _____

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# PATIENT RESPONSIBILITIES

**As a patient, you are responsible for:**

- Providing the physician and his/her staff with complete and accurate information concerning your health, including any allergies or sensitivities.
- Providing to your physician a current list of your medications, any over-the-counter products and/or dietary supplements.
- Providing accurate and complete information regarding present complaints, hospitalizations, and past illnesses.
- Providing the physician and his/her staff with any changes in your medical condition.
- Following the treatment plan prescribed by your physician.
- Keeping your appointments with your physician and notifying physician when you are unable to do so.
- Providing a responsible adult to transport you home from the facility and to remain with you for 24 hours after a procedure if required by your physician.
- Informing your physician if you have a living will, advanced directive, or medical power of attorney that could affect your care.
- Being considerate of the rights of other patients and clinic personnel.
- Accepting personal financial responsibility for any charges not covered by your insurance.
- The refusal of treatment if you see fit, but understand you are responsible for your actions if you do not accept treatment or do not follow your physician's instructions.
- Changing your physician if you believe it to be necessary or requesting a second opinion.

**At Genesis Health Care Inc., we always strive to make your experience as pleasant and as positive as possible.**

**Patient's Signature:** _____ **Date:** _____

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.**

**If you have any questions about this notice please contact our Privacy Officer at: (843) 393-7452**

**office** 803.254.3676 **web** www.GenesisFQHC.org **email** info@genesisfqhc.org

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## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

## WHO WILL FOLLOW THIS NOTICE

This notice describes our facility's practices and those participants listed below in our organized health care arrangement. As such, we may share your medical information and the medical information of others we service with each other as needed for treatment, payment or health care operations relating to our organized health care arrangement.

**This notice does not imply any joint venture or any other special association or legal relationship between the facility and its medical staff. This notice is an administrative tool permitted by federal law allowing the facility and medical staff to tell you about common privacy practices.**

Along with the facility, the following participate in our organized health care arrangement:

- Members of our medical staff and their employees or workforce who provide services or support to the physician at the facility.
- Our employed physicians and their office staff.

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# USES AND DISCLOSURES OF MEDICAL INFORMATION

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

**Treatment:** We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

**Payment:** We may use and disclose your medical information to obtain payment for services we provide to you. We may disclose your medical information to another health care provider or entity subject to the federal and state Privacy Rules so they can obtain payment.

**Health Care Operations:** We may use and disclose your medical information in connection with our health care operations. These uses are necessary to make sure that all our patients receive quality care.

Some examples are:

- Review of our treatment or services to evaluate the performance of our staff providing your care;
- Sending you a satisfaction survey;
- Review of information about many of our patients to determine if additional services should be added or perhaps are no longer needed;
- Information may be given to our doctors, nurses, medical and health care students, and other personnel to be used for education and learning purposes;
- We may remove information that identifies you from the medical information so others may use it for studies in health care delivery without learning who the patients are; and
- We may disclose your medical information to another provider who has a relationship with you and is subject to the same Privacy rules, for their health care operation purposes.

**On Your Authorization:** You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

**Appointment Reminders:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the facility.

**To Your Family and Friends:** Unless you object, we may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.
We will also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of medical information.

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## USES AND DISCLOSURES OF MEDICAL INFORMATION (CONT'D)

**By Law or Special Circumstances:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials after receiving subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates;

**Health-Related Benefits and Services:** We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities.

We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

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## USES AND DISCLOSURE OF CERTAIN TYPES OF MEDICAL INFORMATION

For certain types of medical information we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your medical information for purposes of use or disclosure of your medical information:

**Sexually Transmitted Disease Information:** We may not disclose HIV information unless required by law, pursuant to an authorization or the disclosure is to you or your personal representative; or, to medical personnel to the extent necessary to protect the health or life of any person.

**Genetic Information:** We may only disclose your genetic information to for the following purposes: as necessary for the purpose of a criminal or death investigation, or a criminal or judicial proceeding or inquest, or a child fatality review; pursuant to court order; to law enforcement or government agency for purpose of identifying a person under appropriate circumstances or a dead body; or to other persons as may be required by law.

**Alcohol and Drug Abuse Information:** We may not disclose your medical information that contains alcohol and drug abuse information except to you, your personal representative or pursuant to an authorization or as may otherwise be allowed by law.

## YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

**Right to Inspect and Copy:** You have the right to look at or get copies of your medical information, with limited exceptions. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a fee for copying and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
We may deny your request to inspect and copy in very limited circumstances as allowed by law. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, since April 14, 2003. You must make a request in writing to request a listing of disclosures. You may obtain a form to request the accounting by using the contact information at the end of this notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

**Restriction:** You have the right to request that we place certain restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing. You may obtain a form to request additional restrictions on the use or disclosure of your medical information by using the contact information listed at the end of this notice. We will not be bound to the restrictions unless our agreement is signed by you and the appropriate facility representative.

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## YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU (CONT'D)

**Confidential Communication:** You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. For example, you might request that we contact you at work or by mail. You must make your request in writing. You may obtain a form to request alternative communications by using the contact information listed at the end of this notice. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. Your request must be in writing, and it must explain why the information should be amended. You may obtain a form to request an amendment by using the contact information listed at the end of this notice. We may deny your request if we did not create the information you want amended and the individual who provided the information remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

**Electronic Notice:** If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

If you want more information about our privacy practices or have questions or concerns, please contact Genesis Health Care Inc. using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: PRIVACY
Telephone: 843-393-7452
Address: 201 Cashua Street, Darlington, SC 29532

**HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT**
I have been given the opportunity to read the HIPAA Notice of Privacy Practices for Protected Health Information.

**Patient's Signature:** _____ **Date:** _____

****You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice. If you have any questions about this notice please contact our Privacy Officer at: (843) 393-7452**

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# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Please Fax Records to Attention:** _____

I authorize the use and disclosure of my individual health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. (Note: S.C. Law prohibits the re-disclosure of mental health records).

**Patient's Name:** _____ **Date Requested:** _____

**DOB:** _____ **Social Security #:** _____ **MR #:** _____

**Person/Organization disclosing the information:** _____

**Person/Organization receiving the information (Check all that apply):**

☐ **Pee Dee Health Care**
201 Cashua St
Darlington, SC 29532
Phone: (843) 393-7452
Fax: (843) 393-6210

☐ **Olanta Family Care**
211 S Jones Rd
Olanta, SC 29114
Phone: (843) 396-9730
Fax: (843) 396-9735

☐ **Lamar Family Care**
301 W Main St
Lamar, SC 29069
Phone: (843) 395-8400
Fax: (843) 395-8401

☐ **Walterboro Family Care**
457 Spruce St
Walterboro, SC 29488
Phone: (843) 781-7428
Fax: (843) 781-7429

☐ **Dr. Brent Baroody OB/GYN**
1523 Heritage Ln #A
Florence SC, 29505
Phone: (843) 673-9992
Fax (843) 673-9996

**Information for treatment period:** **From (Date):** _____ **To (Date):** _____

☐ **Office Notes** ☐ **Hospital Notes** ☐ **Laboratory Test** ☐ **Consults** ☐ **Radiology Reports**

☐ **Ancillary Testing Reports** ☐ **Other (please specify):** _____

**Purpose(s):** ☐ **Insurance** ☐ **Legal Investigation** ☐ **Disability Evaluation** ☐ **Other:** _____

OR ☐ I may request my information be released to me to exercise my right to access and obtain a copy of my PHI.

A) I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to me.

B) I understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment) and/or State Law (such as mental health, AIDS or HIV).

C) I understand that I may revoke this Authorization at any time. However the revocation will not apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the Privacy Officer to initiate the revocation process.

D) I understand my treatment by Genesis Health Care Inc. is not conditioned upon whether or not I provide authorization for the requested use or disclosure of my PHI.

E) I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby release Genesis Health Care, Inc from any liability or damages arising in connection with or related to the use and/or disclosure of my protected health information pursuant to this Authorization.

_____ _____ _____
**PATIENT NAME - PRINT** **PATIENT SIGNATURE** **DATE**

_____ _____ _____
**AUTHORIZED REPRESENTATIVE** **RELATIONSHIP TO PATIENT** **TELEPHONE NUMBER**

DATE: _____

Dear Applicant,

Genesis Health Care, Inc. invites you to apply for our Sliding Fee Program. We are dedicated to providing quality health care at affordable prices to residents of our community. Eligibility for the program is based on several factors, including your annual household income and the family size of those living in the household. Please fill out the attached paperwork in full and return it to us with the necessary documentation. All information provided will be kept on file and in strict confidence.

Completed applications will be processed, and a letter with your discount determination will be mailed to you. If your application is denied, we will mail you a letter with an explanation of denial.

Missing information or incomplete applications will place the application on hold until we receive all necessary information to determine the appropriate discount level. To continue to qualify, you must verify family household income and size on an annual basis. If you have any questions, please feel free to call (843) 393-7452 during normal business hours and ask for a Financial Counselor.

Thank you for your cooperation in turning in a complete application so that we may help you obtain financial assistance for your healthcare services here at Genesis Health Care.

Sincerely,

Genesis Health Care, Inc.

**Applicant Name: Last_____ First _____ Account # _____**

## Sliding Fee Scale Application

**Proof of acceptable income includes, but is not limited to: your yearly income tax return (must be completed), copy of your last month's paycheck stubs, current bank statement showing direct deposit. If you do not have the prior proof you may sign the Patient Financial Self-Attestation Agreement.**

| | | | |
|---|---|---|---|
| First Name: | Middle: | Last: | |
| Home Address: | City: | State: | Zip: |
| Phone #: | Date of Birth: | | |
| Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed | | | |
| Do you consider yourself homeless? □ yes □ no | Have you applied for medical assistance? □ yes □ no | | |
| Do you or any family member of your household receive Medicare Extra Help or any other type of low-income subsidy? □ yes □ no | | | |
| If no, would you like assistance in applying for any extra help? □ yes □ no | | | |

| To Be Completed by Patient/Guardian for EACH family member of the household | | Name | Relationship | DOB | Health Insurance | Income Verification Method | Income Frequency | Income | GHC Patient? | Account Number |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1. | | | | | | | | | |
| | 2. | | | | | | | | | |
| | 3. | | | | | | | | | |
| | 4. | | | | | | | | | |
| | 5. | | | | | | | | | |
| | 6. | | | | | | | | | |
| | 7. | | | | | | | | | |

Total Annual Income:_____

***Patient Financial Self-Attestation Agreement/Acknowledgement***

____ ***I understand that Genesis Health Care, Inc. will use the information that I have provided to determine my financial eligibility for federally subsidized health care. I further attest that the information that I have provided to Genesis Health Care, Inc. is true and correct. I understand it is my responsibility to notify GHC of any changes to my income. I also understand that I must re-apply for the sliding fee program every 12 months, or sooner if my family household income changes.***

***OR***

____ ***I acknowledge that I have been provided information related to this Application and DECLINE to participate at this time.***

**Print Name: _____** **Date: _____**

**Signature: _____** **Relationship to Patient: _____**

**Reason for Decline (if applicable): _____**

Additional Social/Other Considerations:

1. Please indicate participation in any of the following other financial assistance programs (mark all that apply):

___ Disability assistance including SSI, SSDI ___ Veteran Assistance ___ Workers Compensation

___ Private Short/Long Term Disability Benefits ___ Temporary Assistance for Needy Families

___ Water Assistance ___ Other

2. Please indicate if you are affected by any of the following ADL (activities of daily living) Difficulties (mark all that apply):

___ Eating ___ Mobility ___ Bathing ___ Toileting ___ Dressing

3. Please indicate if you suffer from any of the following Illnesses (mark all that apply):

___ ALS ___ Cancer ___ MS ___ Parkinson's ___ Alzheimer's ___ 3 or more chronic diseases

*If 3 or more chronic diseases are checked, please list: _____

4. Please indicate if you take any of the following medications based on a diagnosed diseased (mark all that apply):

____ Oncology Medications _____ Specialty Medication ____ A single medication with out of pocket cost exceeding $100 per month

5. Do you have difficulty paying monthly expenses and for needed medications? ___ Yes ___ No

   If yes, please explain:

6. Do you take 7 or more medications per month? ___ Yes ___ No

7. Please indicate the % of monthly/annual income contributed to the following:

   _____ Health Care Expenses (other than medications)
   _____ Student Loan
   _____ Dependent Care Expense(s)
   _____ Other

   _____ Total Monthly/Annual % of Income

***Patient Financial Self-Attestation Agreement/Acknowledgement***

***Patient Attestations (please initial)***

___ If my application is approved, I request all my medications be filled by a GHC pharmacy;

___ I have the freedom to have my prescriptions filled at any pharmacy and voluntarily choose to use the services of Professional Pharmacy and understand that I can choose another pharmacy of whenever I wish by notifying GHC in writing;

___ I request that my prescriptions be filled using brand name drugs when available. This statement and request remains in full force and effect until I request otherwise, in writing;

___ I acknowledge that GHC may obtain Prior Authorizations for brand name medications as authorized by me in this document;
___ I agree and request that GHC process all manufacturer coupons on my behalf;
___ I authorize GHC to deliver or mail my prescriptions to me in the event I am unable to pick them up;
___ I agree to take all medication as prescribed and will notify GHC immediately in the event I am unable to follow prescribed medication instructions;
___ I certify under penalty of law based on information and beliefs formed after reasonable inquiry, the statements contained in this document are accurate and complete; and
___ I will actively participate in any programs prescribed by my physicians such as Case Management, Disease Management, Preventive Care, wellness programs, and other such programs and/or services.

***I attest that the above information provided to GHC is true and accurate. I understand it is my responsibility to notify GHC of any changes to my income and that I must re-apply for this program every 12 months, or sooner if my family household income changes.***

**Print Name:** _____

**Signature:** _____ **Date:** _____/_____/_____

***I decline to utilize a GHC pharmacy to fill my medications and wish to have any prescription medication filled at a different pharmacy of my choice.***

**Print Name:** _____

**Signature:** _____ **Date:** _____/_____/_____

***I attest that I have explained the application to the patient, reviewed all information provided by the patient, confirmed that all required documentation is present, answered all questions related to the application, and have determined the application has been completed in its entirety.***

**Signature of GHC Staff:** _____ **Date:** _____/_____/____

*GHC STAFF USE ONLY:*

Applicant Name:

Last: _____ First: _____ Account #: _____

**Qualification Determination:**

**2020 OFFICE VISITS**

| | LEVEL A 100% of FPG Nominal Fee of $15 or *$0 | | LEVEL B 100% - 125% FPG Pay 15% of Standard Fee | | LEVEL C 125% - 150% FPG Pay 30% of Standard Fee | | LEVEL D 150% - 175% FPG Pay 50% of Standard Fee | | LEVEL E 175% - 200% FPG Pay 70% of Standard Fee | | LEVEL F 200% - 300% FPG Pay 100% of Standard Office Visit Fee | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Family Size** | **Annual Income from:** | **to:** | **Annual Income from:** | **to:** | **Annual Income from:** | **to:** | **Annual Income from:** | **to:** | **Annual Income from:** | **to:** | **Annual Income from:** | **to:** |
| **1** | **$0.00** | **$12,760** | **$12,760.01** | **$15,950** | **$15,950.01** | **$19,140** | **$19,140.01** | **$22,330** | **$22,330.01** | **$25,520** | **$25,520.01** | **$38,280** |
| **2** | **$0.00** | **$17,240** | **$17,240.01** | **$21,550** | **$21,550.01** | **$25,860** | **$25,860.01** | **$30,170** | **$30,170.01** | **$34,480** | **$34,480.01** | **$51,720** |
| **3** | **$0.00** | **$21,720** | **$21,720.01** | **$27,150** | **$27,150.01** | **$32,580** | **$32,580.01** | **$38,010** | **$38,010.01** | **$43,440** | **$43,440.01** | **$65,160** |
| **4** | **$0.00** | **$26,200** | **$26,200.01** | **$32,750** | **$32,750.01** | **$39,300** | **$39,300.01** | **$45,850** | **$45,850.01** | **$52,400** | **$52,400.01** | **$78,600** |
| **5** | **$0.00** | **$30,680** | **$30,680.01** | **$38,350** | **$38,350.01** | **$46,020** | **$46,020.01** | **$53,690** | **$53,690.01** | **$61,360** | **$61,360.01** | **$92,040** |
| **6** | **$0.00** | **$35,160** | **$35,160.01** | **$43,950** | **$43,950.01** | **$52,740** | **$52,740.01** | **$61,530** | **$61,530.01** | **$70,320** | **$70,320.01** | **$105,480** |
| **7** | **$0.00** | **$39,640** | **$39,640.01** | **$49,550** | **$49,550.01** | **$59,460** | **$59,460.01** | **$69,370** | **$69,370.01** | **$79,280** | **$79,280.01** | **$118,920** |
| **8** | **$0.00** | **$44,120** | **$44,120.01** | **$55,150** | **$55,150.01** | **$66,180** | **$66,180.01** | **$77,210** | **$77,210.01** | **$88,240** | **$88,240.01** | **$132,360** |

**Based on patient's ability to pay*

**Additional Data Utilization Populations (all groups below pay 100% of Standard Office Visit fee):**

- **Level G – Patients at 301% of poverty or greater that meet additional social/other considerations as identified in SF Application Page 3**

**For family units with more than 8 members, add for each additional member:**

| | |
|---|---|
| **100% of poverty** | **$4480** |
| **125% of poverty** | **$5600** |
| **150% of poverty** | **$6720** |
| **175% of poverty** | **$7840** |
| **200% of poverty** | **$8960** |
| **300% of poverty** | **$13440** |

**2020 ANCILLARY SERVICE**

| | LEVEL A | LEVEL B | LEVEL C | LEVEL D | LEVEL E | LEVEL F |
|---|---|---|---|---|---|---|
| **Bone Density** | **$5.00** | **$7.00** | **$9.00** | **$11.00** | **$13.00** | **Full Ancillary Fee** |
| **Radiology** | **$10.00** | **$12.00** | **$14.00** | **$16.00** | **$18.00** | **Full Ancillary Fee** |
| **Ultrasound** | **$10.00** | **$12.00** | **$14.00** | **$16.00** | **$18.00** | **Full Ancillary Fee** |
| **Echocardiography/ Vascular Testing** | **$10.00** | **$12.00** | **$14.00** | **$16.00** | **$18.00** | **Full Ancillary Fee** |
| **Lab** | **$15.00** | **$17.00** | **$19.00** | **$21.00** | **$23.00** | **Full Ancillary Fee** |

***Level F is calculated to obtain utilization data and requires payment of 100% of fee associated with ancillary service**

*GHC STAFF USE ONLY:*

Applicant Name:

Last: _____ First: _____ Account #: _____

**_____ The applicant qualifies for the Sliding Fee Program and will be classified as follows:**

**SLIDE LEVEL:** _____

**This qualification is for a 12 month period ending: _____/_____/_____**

Date card mailed: _____/_____/_____ Date entered in EMR: _____/_____/_____

**_____The applicant does not qualify for the Program at this time**

Letter of Denial Sent: _____/_____/_____

***I attest that I have explained the application to the patient, reviewed all information provided by the patient, confirmed that all required documentation is present, answered all questions related to the application, and have determined the application has been completed in its entirety.***

Signature of GHC Staff: _____ Date: _____/_____/_____