Health Care for the Homeless

2222 Simon Bolivar Ave.
N. O., LA. 70113

1530 Gravier Street
N. O., LA. 70112

Registration Form

Has the patient received services at HCH before? □ Yes or □No

Patient's Information

Last Name _____
First Name _____ Middle _____
Date of Birth _____ Religion _____
Social Security Number: _____
Street Address _____
P.O. Box (if applicable) _____
City _____ State _____ Zip _____
Home Phone ( ) _____
Cell Phone ( ) _____
E-mail address _____
Sex: M F Transgender: ☐ F to M ☐M to F
Sexual Orientation: ☐ Lesbian or Gay ☐ Straight
☐Bisexual ☐Something Else ☐ Don't Know
☐Choose not to disclose ☐Unknown
☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Race: ☐Hispanic/Latino ☐Non-Hispanic/Latino
Ethnicity: ☐ American Indian/Alaska Native
☐ Asian ☐ White ☐ Multiple Races ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander
☐ Prefer not to answer
Primary Language ☐ English ☐ Spanish ☐ French
☐Chinese ☐ Japanese ☐Other _____
Are you an Agricultural Worker? ☐ Yes ☐ No
Are you a Veteran ☐ Yes ☐ No
Occupation _____
Employer _____
Work Address _____
City _____ LA _____ Zip _____
Work Phone ( ) _____
Employment Status: Full-Time ☐Part-Time☐ None
Student Status: ☐ Full-Time ☐ Part-Time ☐ None
Housing Status: ☐ Street/Homeless ☐ Homeless Shelter
☐ Transitional ☐ Doubling up ☐ Institutional
☐ Permanently Housed, not Homeless
☐ Permanent Supportive Housing ☐Unknown
☐ Public Housing ☐Guste Homes ☐ Other _____

Parent Information (If patient is a minor.)

Last Name _____
First Name _____
Relationship to Patient _____
Date of Birth _____
Social Security Number _____
☐Single ☐Married ☐ Divorced ☐Separated ☐Widowed
Street Address _____
City _____ State _____ Zip _____
Home Phone ( ) _____
Cell Phone ( ) _____
Email Address _____

Emergency Contact Information

Please list the name of a friend or relative that does not live with you that can be contacted in case of an emergency.

Name _____
Relationship to Patient _____
Phone _____
Address _____
City _____ State _____ Zip _____

Insurance Information

First Policy:

Insurance Company _____
Phone # to Verify Coverage ( ) _____
Policy Number _____
Does your insurance need to be pre-certified? ☐ Yes ☐ No
Name of Insured _____

Second Policy:

Insurance Company _____
Phone # to Verify Coverage ( ) _____
Policy Number _____
Does your insurance need to be pre-certified? ☐ Yes ☐ No
Name of Insured _____

Other Insurance Information

Please present your Card ☐ **Medicaid** ☐ **Medicare**
☐**NONE** ***Give Discount/Sliding Fee Scale Application.**
Bayou Health Plan ☐Aetna Better Health ☐AmeriHealth Caritas ☐Healthy Blue ☐Louisiana Healthcare Connections ☐United Healthcare Community Plan **Health** ☐Community Health Solutions ☐ Louisiana Healthcare Solutions ☐ United Healthcare Community Plan

Office Use Only

Pt. # _____ Provider _____
Front Desk Clerk Entering Info in EHS _____
Date Entered _____ Time _____

02/13/2019

Health Care for the Homeless
Discounted Sliding Fee Schedule Application

Patient Name: _____ **Date of Birth:** _____

The policy of Health Care for the Homeless is to provide essential medical and dental services regardless of the patient's ability to pay for the healthcare services provided. Discounts are offered based upon family's size and income. Please provide the following information below and return this form to the front desk staff to determine if you or members of your family are eligible for a discount.

The discount will apply to healthcare services received at this clinic at the time of service, but will not cover those services which are purchased from outside our facility. For example, laboratory testing not offered at our clinic, certain medications, and x-ray interpretation by a consulting radiologist, etc.

Discounts are applied for a 6-month period. In the hopes that your financial situation improves, we ask that you notify the clinic as soon as possible to update your information. This form must be updated every 6 months in order to continue to receive the discount. If you have questions, please speak with a front desk staff.

Annual Household Income: Are you the head of Household: Yes ☐ No ☐ Number of persons living in your household: _____

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependent Children Under age 18			
Total			

Note: List and include all sources of income, for example: gross wages, salary, tips, business or self-employment, unemployment or worker's compensation, social security, disability, public assistance, military or veteran's payments, pension or retirement, survivor's benefit, annuities, alimony, child support, and other miscellaneous sources of income.

Please list your spouse and dependents under the age of 18 below.

Dependent's Name	Date of Birth	Gender/Sex	Social Security Number
Spouse			
Dependent			
Dependent			
Dependent			
Dependent			

NOTE: Copies of tax returns, pay stubs, or other information verifying your income may be required before a discount is approved.

I certify that my family size and income shown above is correct.

_____ _____

Patient's Signature Today's Date

Office Use Only

REMEMBER: Verify the patient's address, DOB, social security number, as well as their employment status listed on the patient registration form and/or in Success EHS in the patient's account.

Approved Discount Level: (please circle) A - B – C - D - E – F

ID Provided: Yes ☐ No ☐ ***Insurance Card Provided:*** Yes ☐ No ☐ ***Income Verified:*** Yes ☐ No ☐

Co-Pay Due: $ _____ Amount Paid $ _____ Placed on a Payment Plan: Yes ☐ No ☐

_____ _____

HCH Staff Member's Signature Approval Date

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2222 Simon Bolivar Ave.
N. O., LA. 70113

1530 Gravier Street
N. O., LA. 70112

1111 Newton St.
N.O., L.A. 70114

CONSENT FORM

Please Review Carefully

Patient's Name: _____ Date of Birth: _____

CONSENT FOR TREATMENT: I agree to become a patient of the Health Care for the Homeless (HCH) clinics and I consent to medical and dental treatment, as well as diagnostic testing and/or case management services deemed necessary by the judgement of the physician, nurse practitioner, or dentist assigned to me.

I AM AWARE THAT THE PRACTICE OF MEDICINE AND DENTISTRY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS THE RESULTS OF EXAMINATION OR TREATMENT.

Patient's Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS: I authorize direct payment to HCH, of all medical benefits, settlements, or judgments applicable to my treatment by HCH providers and clinicians at their clinics. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked by me in writing.

THE UNDERSIGNED CERTIFICATES THAT I HAS READ THE FOREGOING, AS THE PATIENT; I DULY AUTHORIZED HCH TO EXECUTE THE ABOVE AND ACCEPT THE TERMS AND CONITIONS.

Patient Signature: _____ Date: _____

RELEASE OF INFORMATION: I authorize HCH and/or its providers and clinicians to disclose all or part of my medical and/or billing records to any insurance carrier or persons employed by the insurance carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on the account as having coverage with the insurance carrier. This authorization includes release of information to group health plans applicable to my treatment. I hereby indemnify and release HCH and its providers and clinicians from any and all responsibility relative to the release of such information.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES: The Notice of Privacy Practices tells you how the Health Care for the Homeless (HCH) Clinics uses and discloses your information. Not all situations will be described. We are required to give you a notice of our privacy practices for the information we collect and keep about you.

I, _____, have been given a copy of the HCH'S Privacy Practices and have had a chance to ask questions about how my information will be used and disclosed.

Patient Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

GREATER NEW ORLEANS HEALTH INFORMATION EXCHANGE (GNOHIE) PATIENT OPT OUT CONSENT POLICY: HCH uses the GNOHIE to store patients' health care information. The GNOHIE provides an easy method that allows your health information to be shared electronically with HCH and other GNOHIE partners, which include your doctors, nurses, and other care providers. This helps your doctors, nurses, and other care providers to work together to provide you care. You can elect not to have your medical records shared through GNOHIE by calling the GNOHIE Service Desk at 1-855-446-6443 (1-855-4GNOHIE) or by submitting an electronic request through the GNOHIE Consent Website, www.gnohie.org. Click on "FAQs" to learn more. If you are under 18 or have a legal guardian, your parent or guardian must opt out for you.

The consent will remain fully effective for one year until it is revoked in writing. You have the right at any time to discontinue services

Updated: 6/12/19

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UNIFORMED PATIENT REFERRAL SYSTEM (UPRS) CONSENT

When you request or receive services from HCH, we collect information about you and enter it into the HCH Uniformed Patient Referral System (UPRS). The HCH UPRS is a confidential referral system contracted by VIA LINK to store patient's linkage to resources. The referral system makes it convenient for agencies and case managers to communicate about patient's referral status within different programs and services. This authorization will allow your information to be entered into our referral system, providing the best care for you.

What information is collected? General demographic information and active referrals/needs/outcomes are inputted and available to all users of the system. Along with that we input a patient assessment for HCH use only, which includes:

- Basic identifying information (name, SSN, date of birth, gender, race, marital and family status, household relationships, phone numbers, military veteran status)
- Housing information (address, type of housing, homeless status, reason for homelessness)
- Income information (sources and amounts of household income, employment information, work skills)

Why should you agree to have your information shared HCH UPRS partnering agencies? By sharing your information with these agencies, you will help us:

- Identify other services or programs you may be eligible for receiving
- Better coordinate services for you and your household
- More accurately count the number of homeless persons, services available and services needed

CLIENT INFORMED CONSENT/RELEASE OF INFORMATION AUTHORIZATION

You have the option to restrict access to personal information that you are providing about yourself and your minor children. You may modify this consent with respect to the sharing of your information at any time.

☐ My information should not be shared with the following program/agencies:

_____

☐ My information may only be shared with authorized personnel in the following program/agencies:

_____

☐ Information about me may only be shared with authorized personnel within this agency.

My Rights:

- I may see and request a copy of any information used/disclosed (as permitted by federal or state law)
- I understand that I can refuse to sign this authorization and my refusal will not affect my ability to obtain services, payment of services, or my eligibility for benefits.
- I can cancel this authorization in writing, at any time, but if I do, it won't affect actions taken before Health Care for the Homeless receives the cancellation. I can send the notification to cancel authorization to 2222 Simon Bolivar, 2nd Floor, New Orleans, LA, 70113.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Your release of information authorization is valid to a maximum of three years from the date of this document. You may cancel this authorization at any time by written request, and the cancellation will not be retroactive. Signing this form does not waive non-disclosure rights.

_____ _____ _____ _____

SIGNATURE OF CLIENT DATE SIGNATURE OF AGENCY WITNESS DATE