NUESTRA CLINICA DEL VALLE
REGISTRATION FORM

Nuestra Clinica del Valle is a federally qualified community health center that is required to obtain certain information in order for you to qualify for discounts. If you are interested in receiving discounts, please complete this form in its entirety. ***If you do not want to qualify for discounts, only complete patient demographic and insurance information if any.*** This information will assist us in determining the level of discount you and your family may receive for medical/dental services at NCDV. The requirements for discounts we need to verify is gross annual income, residency, and proof of identity. The discounts will be calculated on an annual basis using income and family size utilizing the Federal Poverty level guidelines. This process is done initially and yearly there after and/or whenever there is a change to household information regarding income, family size, changes to address, and/or insurance coverage.

APPLICANT INFORMATION: ***Proof of Identity*** is required for all applicants; Picture ID, SS Card, Birth Certificate, etc. *(There may be other documents required if deemed necessary by registration clerk when applying for discounts.)*

Name:_____ Date of Birth: _____

Address: _____ Social Security Number: _____

City: _____ ST Zip Code _____ Phone Number: _____

Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Unknown

RESPONSIBLE PARTY FOR THIS ACCOUNT: **(***if different from the person applying for services)*

_____/_____/_____

Full Name or Responsible Party **Date of Birth** **Social Security Number**

Do you have insurance? ☐ No ☐ YES

INSURANCE COVERAGE: ***Proof of Insurance*** is required for verification of benefits, example: card, letter from insurance, etc.

☐ Medicare ☐ Medicare Supplement ☐ Medicaid ☐ CHIP ☐ Private Insurance ☐ County

***Applicant Information*:**

Race: ☐ White ☐ Black ☐ Asian ☐ Native American ☐ More than One Race

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ All Others

Veteran: ☐ Yes ☐ No

Name of person and phone number whom we may contact in case of an emergency:

Name:_____ Relation to Patient:_____

Phone Number:_____ Alternate number:_____

Have you worked locally or migrated within the past two years to work in a job that is related to a life sustaining product? ☐ No ☐ Yes **If yes**: ☐ Locally ☐ Migrates (*leaves primary home to go work for this job*)

Examples: *preparing land, planting, picking, packing, and/or transporting life sustaining products such as vegetables, milk, poultry, fish, cattle, etc. Worked in a ranch, poultry farm, fishery, etc.*

Does applicant wish to apply for discounts? ☐ **NO** *(Stop Here)* ☐ **YES**

If yes: *continue completing the following information and provide* ***Proof of Residency****: a utility bill that shows the address.*

Total Number of Family Members living at home and supported by household income:_____

Is your household a single family household? ☐ Yes ☐ No - ***If you leave with someone***:

Do you support self or does person you live with support your household? ☐ Self ☐ Other Person(s)

INCOME INFORMATION: ***Proof of Income*** is required and can be any of these sources: payroll check stubs (one month total), income tax return, W2 Forms, and/or Notarized Letter for self employed applicant who does not have social security number.

Please tell us how often person is paid: W – Weekly; B – Bi-Weekly *(every other wk);* ***M – Monthly; BM – Bi-monthly*** *(15th/30th)*

Earned Income:	***Amount***	***How often?***
Gross Self Income:	$	
Gross Others Income:	$	

For clerk's calculations of annual income:

Unearned: ***Do you receive funds from any of the following sources: If so, how much and how often?***

Social Security	$	/ Monthly	Retirement/Pension	$	/ Monthly
Public Assistance/TANF	$	/ Monthly	Food Stamps	$	/ Monthly
Child Support Alimony	$	/	Other	$	/

FAMILY MEMBERS INFORMATION: **(*Relationship:* S–*Self;* SP–*Spouse;* SO–*Son;* D–*Daughter;* O-** *Other* **and Insurance if any)**

Name	**DOB**	**SSN (*If Applicable*)**	**Relationship**	**Insurance** *(If applicable)*
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

I attest under penalty of perjury that the information provided is true and correct to the best of my knowledge. I authorize Nuestra Clinica Del Valle to verify the information I have given herein. I understand that this information will be kept confidential and that I have been given the expiration date to produce proof of income, residency and identification to comply with policies. I understand that if I fail to comply with this request I will lose the privilege to continue receiving discounts based on this certification. I understand that I must notify NCDV of any changes to my income, residency, insurance plan coverage, and family size as soon as change occurs. I understand that failing to comply with the discount application requirements will place me at 100% of charge.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, age, disability, religion, sex, familial status, sexual orientation, and reprisal (not all prohibited bases apply to all programs). ***"This institution is an equal opportunity provider, and employer."***

Patient Signature: _____ **Date**: _____

For Clinic Use Only:

Total Gross Income calculated for household:	**Chart Number Assigned:**	**SF Scale Qualified For:**
	Registration Complete: **( ) Yes**	**Expiration Date:**
$_____	***Incomplete:*** *Circle Pending Documents* ***POI POR Pt ID 30 Days Exp:***	
Registration Clerk Initials:	**Date Application Submitted:**	

Form Updated 1/13