Florida HEALTH
Palm Beach County

DOH-PBC Registration/Eligibility Form

To be filed under eligibility

Part-1: Client Information

Last Name	First Name	Middle Name	Suffix

Date of Birth: (mm/dd/yyyy)	Sex at birth (✓): ☐ Male ☐ Female	Race: Check (✓) all racial categories that apply: ☐ Black/African American ☐ White ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Language (✓): ☐ English ☐ Spanish ☐ Creole ☐ Other (Specify):	Social Security#:	Hispanic? ☐ Yes ☐ No
Were you a single birth? ☐ Yes ☐ No If NO, are you a: ☐ Twin ☐ Triplet ☐ Other (Specify): Were you born? ☐ First ☐ Second ☐ Other (Specify):	Country of Birth (✓): ☐ USA ☐ Other (Specify):	Date Arrived to USA:

Do you have a Living Will (Advance Directive)? ☐ Yes ☐ No If Yes, can you provide us a copy? ☐ Yes ☐ No If No, do you want the form? ☐ Yes ☐ No

Do you wish to receive CONFIDENTIAL Communications of Protected Health Information by an alternative means or alternate address? ☐ Yes ☐ No

If you wish for us to discuss your medical information with someone else, leave you voicemails with test results and/or appointment confirmations you will need to complete our Patient Confidentiality Form. **Do you want to complete the Patient Confidentiality Form?** ☐ Yes ☐ No

Living Address:	Apt#	Check (✓) One as your Primary Contact:
City: State: FL	Zip Code:	☐ Cell Phone#:
Mailing Address: (If different from where you live)	Apt#	☐ Home Phone#:
City: State: FL	Zip Code:	☐ Work Phone#:

Part-2: Emergency Contact

First Name: Relationship:

Last Name:

Phone # ☐ Cell ☐ Home ☐ Work

Part-3: Health Insurance (√)

☐ **Medicaid** ☐ **Medicare** ☐ **Health Care District** ☐ **BC/BS**
☐ **Molina** ☐ **Clear Health Alliance** ☐ **None** ☐ **Other** (Specify):

Part-4: Household Financial Information

Clerical Use Only: No income or family size needed if Immunization only visit (√): ☐ VFC ☐ Adult

IF YOU WOULD LIKE TO WAIVE THE SLIDING FEE PROCESS PLEASE INITIAL HERE _____ WAIVED. By doing this you are agreeing to pay full fee for all your services and your services will not be provided at a discounted rate based on the family size and income. (Note to clerk: No income needed if client waives) Exception is if you are receiving Family Planning Services.

If you would like to participate in the Sliding Fee Process you must provide "Proof of Income" today, based on the following:
MONTHLY GROSS EARNED INCOME: List wages, tips, salaries received monthly from all current employment.
MONTHLY GROSS UNEARNED INCOME: List monies received monthly from sources other than employment. (Examples: All types of Social Security benefits, Unemployment Compensation, Alimony, Workers' Compensation, Veteran's Pension, and Pensions and Annuities. (Do not include SSI or TANF)

FAMILY MEMBERS NAME	DATE OF BIRTH (MM/DD/YYYY)	SEX	HEAD OF HOUSEHOLD (CHECK ONE)	EMPLOYER or OTHER TYPE OF INCOME	CHILD SUPPORT RECEIVED	MONTHLY GROSS EARNED INCOME	MONTHLY GROSS UNEARNED INCOME	AMOUNT PAID FOR CHILDCARE
SELF/PARENT		☐ M ☐ F	☐			$	$	
SPOUSE		☐ M ☐ F	☐			$	$	
CHILD #1		☐ M ☐ F			$	$	$	$
CHILD #2		☐ M ☐ F			$	$	$	$
CHILD #3		☐ M ☐ F			$	$	$	$
CHILD #4		☐ M ☐ F			$	$	$	$
CHILD #5		☐ M ☐ F			$	$	$	$

Are you or any of the family members pregnant? ☐ Yes ☐ No
If yes, Who: _____
Due Date: #of Babies Due:

Are you making any payments for child support? ☐ Yes ☐ No
If yes, how much is paid each month? $

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY CONSENT TO THE PALM BEACH COUNTY HEALTH DEPARTMENT, TO VERIFY THE INFORMATION PROVIDED. I UNDERSTAND THAT GIVING FALSE OR INACCURATE INFORMATION MAY MAKE ME INELIGIBLE FOR SERVICES PROVIDED BY THE CLINIC OR I MAY BE REQUIRED TO PAY 100% OF THE BILL.

Client/Parent/Guardian Signature: ☐ Client ☐ Parent ☐ Guardian Date:

PBCHD Official Use Only: Registered by:_____ Date:_____

Facility: ☐Belle Glade ☐Centering Program ☐Delray ☐Jupiter ☐Lantana/LW ☐Northeast ☐WPB