



Health Care Coalition of Lafayette County
DBA Health Care Collaborative of Rural Missouri
 825 South Business Hwy 13, Lexington, MO. 64067 660-259-2440
DBA Live Well Community Health Centers
 324 S. Hudson St. P.O. Box 512 Buckner, MO 64016 816-249-1521
 1413 N. Jefferson St., Carrollton, MO 64633 660-329-9005
 206 N. Bismark, Concordia, MO 64020 660-463-0234
 608 Missouri St., Waverly, MO 64096 660-493-2262



Today's Date: ____/____/____

Patient Information				
Please Print				
Patient Last Name	First Name	Middle Initial	Preferred Name	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> FTM <input type="checkbox"/> MTF <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other -----
Mailing Address		City	State	Zip
Home Phone #	Cell Phone #	Preferred Contact Method <i>(check all that apply)</i> <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Other		
Email Address: <i>(print below or check the option that applies)</i> <input type="checkbox"/> Do Not Have <input type="checkbox"/> Other <input type="checkbox"/> Choose Not to Disclose			Date of Birth	Social Security Number
Employer Name and Address				Work Phone #
Emergency Contact Name		Emergency Phone #	Relationship to Patient	
Primary Care Physician Name and Phone #			Pharmacy Name and Phone #	

MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Specify		LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		RACE: <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hawaiian Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> More than one race <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other _____	
ETHNICITY: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Other <input type="checkbox"/> Decline			EMPLOYMENT STATUS: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> On Active Military Duty <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student		
VETERAN: <input type="checkbox"/> Yes <input type="checkbox"/> No	HOUSING STATUS: <input type="checkbox"/> Own/Rent <input type="checkbox"/> No Permanent Housing <i>(homeless)</i> ** If No Permanent Housing, where are you currently staying? <input type="checkbox"/> Street <input type="checkbox"/> Doubling up <input type="checkbox"/> Transitional <input type="checkbox"/> Shelter <input type="checkbox"/> Other		TRANSPORTATION STATUS: Do you need help with transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
HAVE YOU BEEN TO THE ER OR ADMITTED TO A HOSPITAL SINCE YOUR LAST VISIT? <input type="checkbox"/> Yes <input type="checkbox"/> No ** If Yes, were you referred to us from the ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No			DO YOU HAVE LIMITED ENGLISH PROFICIENCY? <input type="checkbox"/> Yes <input type="checkbox"/> No		
WOULD YOU LIKE TO BE CONTACTED REGARDING MEDICAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No		DO YOU HAVE A CURRENT ADVANCED DIRECTIVE? <input type="checkbox"/> Yes <input type="checkbox"/> No			
CONSENT TO EXCHANGE RECORDS WITH YOUR OTHER HEALTHCARE PROVIDERS FOR CONTINUITY OF CARE: <input type="checkbox"/> Send & Receive <input type="checkbox"/> Send Only <input type="checkbox"/> Receive Only <input type="checkbox"/> Choose to Opt Out					
WHAT IS YOUR ANNUAL HOUSEHOLD INCOME? _____			HOW MANY PEOPLE LIVE IN YOUR HOUSEHOLD? _____		

The above information is requested by the Federal Government in order to monitor compliance with Federal laws prohibiting discrimination against users of the Live Well Community Health Centers (LWCHC – all locations). You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will be released except in collective form.



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Responsible Party Information

(if different than patient)

Last Name		First Name		Middle Initial	Relationship to Patient
Mailing Address			City	State	Zip
Home Phone #	Cell Phone #	Date of Birth		Social Security Number	
Employer Name	Employer Address			Work Phone #	

Primary Medical Insurance

Name of Insurance Company		Policy ID or Member #	Group #	Effective Date
Insurance Claims Address (<i>Street, City, State, Zip</i>)				Insurance Phone #
Primary Insured's Name	Primary Insured's Social Security #	Primary Insured's Date of Birth		Relationship to Patient

Primary Dental Insurance

Name of Insurance Company		Policy ID or Member #	Group #	Effective Date
Insurance Claims Address (<i>Street, City, State, Zip</i>)				Insurance Phone #
Primary Insured's Name	Primary Insured's Social Security #	Primary Insured's Date of Birth		Relationship to Patient

Secondary Insurance

Medical Dental

Name of Insurance Company		Policy ID or Member #	Group #	Effective Date
Insurance Claims Address (<i>Street, City, State, Zip</i>)				Insurance Phone #
Primary Insured's Name	Primary Insured's Social Security #	Primary Insured's Date of Birth		Relationship to Patient



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THE FOLLOWING AUTHORIZATIONS ARE TO BE COMPLETED AND INITIALED BY A PARENT, LEGAL GUARDIAN OR PERSON REPRESENTING LEGAL CUSTODY TO THE CHILD, PRIOR TO APPOINTMENT WITH OUR PROVIDERS.

ASSIGNMENT OF INSURANCE:

I hereby authorize payment directly to HCC/Live Well Community Health Centers for health care and/or surgical benefits for any services furnished to me or my dependents. I hereby authorize HCC/LWCHC to release any information acquired in the course of my examination or treatment necessary to establish an insurance claim payment. I understand that occasionally my insurance company will deny payment for services that my physician and/or I feel necessary for my good health. Please note that self-pay/sliding scale patients may incur additional charges outside of self-pay office visit fees. I agree to pay for such services in a prompt and timely manner. I hereby authorize HCC/LWCHC providers to prescribe treatment, administer medications, and perform such procedures and tests that may be deemed advisable or necessary in the diagnosis of me or my dependents. _____ **Initials**

RELEASE OF MEDICAL INFORMATION:

I authorize HCC/LWCHC to release information to the following listed below. _____ **Initials**

- Spouse: _____
- Children (list names): _____
- Other: _____

HIPAA NOTICE OF PRIVACY PRACTICES:

I acknowledge that HCC/LWCHC has made available to me the HIPAA notice of privacy practices. _____ **Initials**

AUTHORIZATION TO PROVIDE MEDICAL & HEALTH CARE SERVICES:

I hereby authorize HCC/LWCHC to provide medical examination services, immunological services, and routine medical/health services as considered normal and necessary; to secure and consent to medical, surgical, dental, and psychiatric care that is deemed necessary by a licensed physician, nurse, or mental health provider. _____ **Initials**

APPOINTMENT POLICY:

HCC/LWCHC requires at least 24 hours notice from patients who need to cancel or reschedule an appointment. A patient is considered a No Show, if they are 15 minutes late for their scheduled appointment. It is at the discretion of the Clinic Manager or the Provider whether the patient will be rescheduled or if they can be worked into the schedule.

As a patient of the clinic, you and your family agree to:

1. Arrive early or on time to all scheduled appointments
2. Keep the clinic informed of changes to your contact information.
3. Agree that if you No Show for 3 visits within 6 months that you will be placed on a restricted status of, walk-in or same-day appointments only.
4. If you do not show up for an appointment, you will have a No Show appointment. If you do not give at least 24 hours' notice to cancel or reschedule an appointment or you are asked to reschedule due to late arrival, you will have a broken appointment.
5. Due to the high demand for late afternoon appointments, if a member of your family has a Broken or No Show appointment during these times, you may no longer be able to schedule after-school appointments for your family.

IF I AM UNABLE TO BRING MY CHILD(REN) TO AN APPOINTMENT, I GIVE PERMISSION FOR _____ TO BRING THEM.

PATIENT SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY NAME (please print): _____



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Slide Fee Scale Eligibility Application

Are you interested in applying for the Slide Fee Scale option?
 YES NO

**** Documentation must be provided by the patient or guarantor to determine eligibility for the Slide Fee Scale ****

List Family Members within the Household

<u>NAME</u>	<u>FINANCIALLY RESPONSIBLE</u>	<u>DATE OF BIRTH</u>	<u>MONTHLY INCOME (GROSS)</u>
Self	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**** ANYONE THAT IS CONTRIBUTING AND/OR DEPENDENT UPON THE HOUSEHOLD INCOME SHOULD BE LISTED ABOVE ****

ACCEPTABLE INCOME DOCUMENTATION

- Current Federal Income Tax Return ● Form W-2 or Form-1099 ● Paystubs for the last 30 days ● Retirement/Pension Distributions
- Social Security Benefit Letter ● Disability Benefit Letter ● Forms from State Funded Agencies ● Unemployment Compensation
- Official Documents from Courts (Alimony, Child Support, etc.) ● Investment Gains Statement ● Any other Income not Listed

DECLARATION OF NO INCOME

I certify that I am currently unemployed and do not receive any income as of this date. However, I have been receiving support from the following resources which began _____.

- Relatives/Friends
 Energy Assistance
 Section 8 Housing
 TDPA
 Food Stamps
 TANF

- I do hereby attest that this information is true, accurate and complete to the best of my knowledge as well as the below items.
- I have submitted or will provide proof of ALL household income in order for this application to be processed for financial screening.
 - I understand completion of this form does not guarantee a discount.
 - If I do not qualify for a discount, I agree to pay in full or set up a payment plan.
 - If my financial status changes, I agree to provide LWCHC with current documentation of my financial status at my next visit. I also agree to be re-evaluated annually by providing updated income verification.
 - I understand that if I qualify, I must pay a minimum of \$35 per appointment for a medical and behavioral health appointment or a minimum of \$70 for a dental appointment.

APPLICANT'S SIGNATURE: _____

DATE: _____



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As a recipient of Federal financial assistance, the Health Care Collaborative of Rural Missouri and its clinics: Live Well Community Health Center – Buckner, Carrollton, Concordia and Waverly, do not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by the Health Care Collaborative of Rural Missouri and its clinics: Live Well Community Health Center – Buckner, Carrollton, Concordia and Waverly, directly or through a contractor or any other entity with which the Health Care Collaborative of Rural Missouri and its clinics: Live Well Community Health Center – Buckner, Carrollton, Concordia and Waverly, arranges to carry out its programs and activities.

Health Care Coalition of Lafayette County						
dba/ Livewell Community Health Centers						
Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Based upon 2019 Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)						
Poverty Level	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Slide A	Slide B	Slide C	Slide D	Slide E	Full Pay
1	\$0 - \$12,490	\$12,491 - \$15,613	\$15,614 - \$18,735	\$18,736 - \$21,858	\$21,859 - \$24,980	\$24,981+
2	\$0 - \$16,910	\$16,911 - \$21,138	\$21,139 - \$25,365	\$25,366 - \$29,593	\$29,594 - \$33,820	\$33,821+
3	\$0 - \$21,330	\$21,331 - \$26,663	\$26,664 - \$31,995	\$31,996 - \$37,328	\$37,329 - \$42,660	\$42,661+
4	\$0 - \$25,750	\$25,751 - \$32,188	\$32,189 - \$38,625	\$38,626 - \$45,063	\$45,064 - \$51,500	\$51,501+
5	\$0 - \$30,170	\$30,171 - \$37,713	\$37,714 - \$45,255	\$45,256 - \$52,798	\$52,799 - \$60,340	\$60,341+
6	\$0 - \$34,590	\$34,591 - \$43,238	\$43,239 - \$51,885	\$51,886 - \$60,533	\$60,534 - \$69,180	\$69,181+
7	\$0 - \$39,010	\$39,011 - \$48,763	\$48,764 - \$58,515	\$58,516 - \$68,268	\$68,269 - \$78,020	\$78,021+
8	\$0 - \$43,430	\$43,431 - \$54,288	\$54,289 - \$65,145	\$65,146 - \$76,003	\$76,004 - \$86,860	\$86,861+
For each additional person, add	\$4,420	\$5,525	\$6,630	\$7,735	\$8,840	\$8,840
Medical per visit rates	Pay lesser of total charges or Nominal Fee of \$35 per visit	Pay lesser of total charges or \$50 per visit	Pay lesser of total charges or \$75 per visit	Pay lesser of total charges or \$100 per visit	Pay lesser of total charges or \$125 per visit	Pay 100% of Charges per visit
Patients will be responsible for 100% of the discounted lab services and any medical devices or implants						
Dental per visit rates	Pay lesser of total charges or Nominal Fee of \$70 per visit	Pay greater of 20% of Charges per visit or \$75	Pay greater of 40% of Charges per visit or \$75	Pay greater of 60% of Charges per visit or \$75	Pay greater of 80% of Charges per visit or \$75	Pay 100% of Charges per visit
Patients will be responsible for 100% of lab services and dental materials prepared off-site						