Healthcare for the Homeless
Community Action Partnership

Date_____

Are you a patient at another clinic? _____ If yes, please stop and speak to the records assistant.

Social Security Number		Date of birth (mm/dd/yyyy)
Last Name First Name Middle Name		
Street address	City State Zip	
Home phone number	Cell phone number	Gender at birth: □ Male □ Female

Patient Portal Access Disclosure:

Email:_____

I hereby authorize HEALTH CARE FOR THE HOMELESS to use/disclose individually information to the FOLLOW MY HEALTH patient portal for my online access to HEALTH CARE FOR THE HOMELESS health care information.

Signed: X_____Date_____

What is your marital status?(check one)
□ Divorced □ Married □ Single □ Domestic partner □ Separated □ Widowed

Are you Currently Employed? □No □Part Time □Full Time □ Looking for work.

Student Status:(check one) □Student full time □ Student part time □ Minor □ Not a student

Please check one of the following from the race listing:
□ Asian □ Native Hawaiian □ Other Pacific Islander □ Black/African American
□ American Indian/Alaskan Native □ White

Please select one of the following from the ethnicity listing:
□ Hispanic □ Not Hispanic

VERIFICATION OF HOMELESS STATUS:

If you are homeless, where did you stay/sleep last night?
□ *Homeless shelter* □ *Street* □ *Transitional Housing*
□ *Car or other Vehicle* □ *Other* □ *Hotel/Motel*
□ I am staying with another person/organization at this time.

I certify that I do not have any type of permanent housing at this time.

*Signed: X*_____ *Date:*_____

1514 East 12th St, Suite 201 Casper, WY 82601 Phone: 307-235-6116 Fax: 307-235-0249

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Name:_____

Emergency contact: Spouse, Friend, Legal Guardian or Parent (if patient is a minor)	
Relationship to patient	Phone number
Street address City State Zip	

Do you need an Interpreter? □ Yes □ No
Are you disabled □ Yes □ No
Are you a Veteran? □ Yes □ No

How did you hear about our clinic?
□ Friend/Family □ Mission □ CRC □ CWCC □Community Action □ Other Organization
□ Facebook □ Web Search

Do you have:

- □ Social Security
- □ SSI
- □ SSDI
- □ Medicaid
- □ Medicare
- □ Insurance

If yes: ID #_____ Group #_____

This will **NOT** affect your eligibility with us, but is very important for us to be able to bill correctly, as well as other services that we may be able to provide.
We can help you find the ID and group number for you, please ask!

Are you resident of the Housing First Program? □ Yes □ No

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CONSENT TO TREATMENT

I hereby request and consent to diagnostic procedures, tests, and medical treatment, family planning, birth control methods, and immunizations as deemed advisable by the professional staff of Healthcare for the Homeless. I am aware that a Physician or a Nurse Practitioner may provide the medical care. Services will be in my best interest, or the best interest of my child or legal charge. I understand that this consent to treatment will be in effect as long as I am seen at any of the 12th Street Clinic sites. I may cancel this consent in writing.

Signed: X_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices from 12th Street Clinic.

Signed: X_____ Date:_____

Agreement to See Only One Primary Care Provider

In order to offer the best possible care, we ask our patients to use only one Primary Care Provider (doctor/PA/NP/etc.) for their general medical needs. We always want to be aware of our patients' medical concerns and needs. We encourage you to choose a Primary Care Provider that you trust and feel comfortable with. We would be more than happy to assist you in finding other medical care if our clinic does not meet your needs. We ask that our patients always let us know when they have been to the Emergency Room so we can offer thorough follow-up care.
I understand, have read, and agree to the Healthcare for the Homeless policy of only seeing one provider.

Signed: X_____ Date: _____

PATIENT FINANCIAL POLICY

Payment is expected in full when services are rendered. The following is the HCH Patient Financial Policy.
Regarding Medicare: Please provide us with your current Medicare Card at each visit. If you have a share of cost, you will be asked to pay that amount at the time of service.
Private Insurance: Please provide us with a copy of your insurance card at each visit. All co-pays and deductibles are due at time of service.
Private Pay Patients: Full payment is due at time of service. The HCH accepts Cash and Checks. We offer a sliding fee discount if you qualify. Please ask a receptionist for additional information. All sliding fee program co-pays are expected at the time of service.
Government Funded Programs: We offer several different government funded programs in which you may qualify. If you would like more information please ask our receptionist.
Thank you for choosing us as your health care provider. Please let us know if you have questions or concerns. By signing below you acknowledge and accept our Patient Financial Policy.

Signed: X_____ Date:_____

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Healthcare for the Homeless (HCH) is NOT a Retail Pharmacy; it is a dispensing site for clinic patients only. Please read and sign the following in acknowledgment of your understanding of the HCH medication dispensing procedure.

- Medications WILL NOT be dispensed to any new patient prior to being seen by a clinic provider.
- Written prescriptions from non-HCH providers will not be filled.
- Medications and/or prescriptions that are lost, stolen, damaged (i.e. water, etc), or overused will not be replaced. You will need to schedule a follow up appointment to discuss this with your provider.
- The medication stock at HCH will vary from time to time. If medications become unavailable through HCH dispensary, a written prescription will be provided.
- HCH medication refills must be requested by Wednesday at 5pm. Refills will be ready to pick up by the following Tuesday afternoon.
- Clinic staff will attempt to contact you when your refill is ready.
- You are responsible for notifying clinic staff of any changes to your phone number/contact information.
- You are responsible for contacting the clinic with any questions you have about your refills.
- If a delegate will be collecting your prescriptions, they must have your written permission and a Photo ID in order to collect any medication.
- Medications that are not collected within ten days of being filled will be returned to the clinic stock.
- All patients are charged a $2.00 processing fee per medication.

Printed Name: _____

Signed: X_____ Date:_____

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Authorization for Use and/or Disclosure of Protected Health Information (PHI) (to Obtain)

I hereby request, from the facility named below, the release of my Protected Health Information:

Facility Name (Place that has treated you in the past.) _____

Facility Address: _____

Phone #_____FAX#:_____

Date of service (s):_____ to _____ □ All Dates

_____ _____
Patient Last Name First Name M.I Date of Birth

_____
Street Address City State Zip Code

(____) _____ (_____)_____
Home Phone Work Phone

The Protected Health Information to be released:

□ Entire Record □ Hospital Report □ Ultrasound Report □ Medical History
□ Prenatal Records □ Immunization Record □ X-Ray □ Other:

I specifically authorize the release of Protected Health Information relating to:
□Substance abuse (including alcohol/drug abuse) □Mental Health (including psychotherapy notes)
□HIV related information (AIDS related testing)

_____ _____
Signature of Patient or Legal Guardian Date

The Protected Health Information will be released to:
12th Street Clinic 1514 East 12th St, Building E, 3rd Floor Casper, WY 82601

This authorization is effective now and will remain in effect until _____ (date) or one year from date of signature, whichever is sooner.

My Rights

I understand I do not have to sign this authorization in order to get health care treatment, and if I do not sign, it will not affect the quality of care I receive at Health Care for the Homeless. I understand I may revoke this authorization at any time in writing and I understand revocation will not apply to information that has already been released. Once the office discloses Protected Health Information, the person/organization that receives it may re-disclose it and privacy laws may no longer protect it.

This Information is requested for the following purpose: (Please check all that apply)
□Medical □Legal □Personal □Other

_____ _____
Patient or Parent/Guardian Signature Date Witness Signature/ Print Name Date

For Office Use Only

Patient Name:_____

1. Is applicant eligible for 12th Street Clinic Services □ Yes □ No
2. Financial Resources: Monthly Family Income = _____

   Source: □ Employment □ SSI □ SSDI □ SS

   □ Unemployment □ Other _____
3. Copy of ID: □ Yes□No *If no, explain*_____
4. Was sliding scale explained to patient? □Yes
5. Resident of Housing First Program? □Yes □No
6. Interviewer's Signature: _____ Date: _____

Medicaid Eligibility

Verify ALL patients…they are often eligible without remembering!

MCD ID# _____

MCD Program: _____

Date of Service: _____

Verified by: Initials _____ Date: _____

1-800-251-1268 * Follow prompts for eligibility**

We bill with National Provider Identification (NPI) = 1629121330

Programs: SSI, Adults, Children, BCCSP (breast&cervical cancer), CCSP(colorectal cancer)

Healthcare for the Homeless Patient Portal

Due to the COVID-19 Outbreak, until further notice we may use our ***Follow My Health Patient Portal***, scheduled video visit feature. We have been instructed that all insurances are now covering virtual visits.

Please contact us if you do not yet have a portal account and need an invitation. You may also email cmiller@natronacounty-wy.gov or ehodges@natronacounty-wy.gov to receive an invitation.

1. Provide your email address to HCH Staff and give permission to Invite you to join.

2. On your mobile device, go the App Store and INSTALL Follow My Health:

FollowMyHealth®

3. When you provide your email address to the HCH staff, you will receive an **email Invitation** to join. Follow the directions on that email to create your account. Your security code is the last 4 digits of your social security number.

4. Load the Follow My Health app on your mobile phone or ipad; this is the easiest way to get the camera (through the app from the app store). If you do not have a smart phone or tablet, and you do have a video-enabled PC, you can go to our website, www.hch.capnc.org and click on the Patient Portal button. The mobile app is easiest, however. You will need to allow video and audio into the app, in order to see and hear the provider
5. You can request an appointment from the app. View your medical history and prescriptions.

6. You can enter your preferred pharmacy information.

7. If you scheduled a TeleHealth appointment, you will be prompted to Check-in and go to a Virtual Waiting Room. Check-in button is activated 15 minutes before appointment time,

8. When the provider joins that visit you will be notified to Join.