Rosa Clark Medical Clinic Association

PATIENT ENROLLMENT APPLICATION

Name: ______________________________ Date of Birth: __________

SS#: ______________ Male ______ Female ______

Phone #: __________ Alternate #: __________ Email Address: __________

Address: ______________ ______________ ______ ______

Street City State Zip Code

Mailing address if different from above: ______________________________

Race

Black/African American ______ White ______ Asian ______

Native Hawaiian/Pacific Islander ______ American Indian or Native Alaskan ______ More than one race ______

Ethnicity

Hispanic or Latino ______

Non-Hispanic or Latino ______

Preferred Language

English ______

Other ______

Please check if any of these apply to you

Homeless ______ Public Housing Resident ______ Food insecurity ______ Veteran ______

Please list any physician's office, hospital, or medical facility that would have any of your medical records:

____

Please list all prescription and over the counter medication you are taking:

____

____

Allergies

Medication ____

Other ____

Were you recently discharged from the hospital or emergency room?

______ Yes ______ No If yes, when were you discharged? ______

Is your need for an appointment urgent: ______ Yes ______ No

If yes, please describe: ______________________________________

____

If you have insurance please list here: ______________________________

Please provide Insurance Card to Enrollment Coordinator to Copy

To Receive the Sliding Fee Scale Discount, Please Complete the Following, Otherwise Go to Page 3

How many people live at the address above? ________

Please check the sources of income for ***all*** people living at this address:

List the amount of monthly Gross Income for each person in the home:

Self $__________ Source of Income:______________________

Other Household Income $__________ Source of Income:______________________

Other Household Income $__________ Source of Income:______________________

Total Monthly Gross Income $__________

Rosa Clark Sliding Fee Scale 2022

	Plan 1			**Plan 2**			**Plan 3**			**Plan 4**		
Persons in House-hold	**At or below 100% FPL or below**			**At 101% - 125% FPL**			**At 126% - 150% FPL**			**At 151% - 200% of FPL**		
1	0	to	$13,590	$13,591	to	$16,988	$16,989	to	$20,385	$20,386	to	$27,180
2	0	to	$18,310	$18,311	to	$22,888	$22,889	to	$27,465	$27,466	to	$36,620
3	0	to	$23,030	$23,031	to	$28,788	$28,789	to	$34,545	$34,546	to	$46,060
4	0	to	$27,750	$27,751	to	$34,688	$34,689	to	$41,625	$41,626	to	$55,500
5	0	to	$32,470	$32,471	to	$40,588	$40,589	to	$48,705	$48,706	to	$64,940
6	0	to	$37,190	$37,191	to	$46,488	$46,489	to	$55,785	$55,786	to	$74,380
7	0	to	$41,910	$41,911	to	$52,388	$52,389	to	$62,865	$62,866	to	$83,820
8	0	to	$46,630	$46,631	to	$58,288	$58,289	to	$69,945	$69,946	to	$93,260
For families/households with more than 8 persons, add $4,720 for each additional person.												
There is no discount for household income over 200% of the Federal Poverty Guidelines												
Office Visit	$0.00			$2.00			$5.00			$10.00		
Pharmacy Co-pay Per RX	$0.00 per RX			$1.00 per RX			$2.00 per RX			$3.40 per RX		

Dental Clinic Sliding Fee Scale Provided Upon Request

We are required to verify your income in order to provide the sliding fee scale. We can use ***any*** of the following to verify your income:

- Prior Year Income Tax Returns
- Last 4 Paystubs
- Letter of Temporary Living Assistance
- SNAP Eligibility Letter
- Social Security Eligibility Letter

By signing below, I hereby attest:

1) That the above information is true and accurate and I hereby authorize treatment.
2) That I agree to notify the clinic if my address changes or if my insurance status changes.
3) That if I am receiving the sliding fee scale, I will notify the clinic if my income status changes.
4) I understand that Rosa Clark Clinic must be my Primary Care Medical Home in order to receive medications from the Rosa Clark pharmacy.
5) I give Rosa Clark Clinic permission to collect information about me on healthcare services received at facilities other than Rosa Clark including hospitalizations and emergency room visits.
6) I give Rosa Clark Clinic staff permission to enroll me in the SC Medicaid Healthy Connections Checkup Program if I do not have insurance.
7) I agree to re-enroll annually to continue receiving the sliding fee scale at the Clinic.

______________	________________________
Date	Patient Signature

______________	________________________
Date	Enrollment Coordinator

revised 02/10/2022