Siskiyou Community Health Center

Welcome to the Siskiyou Community Health Center!

Thank you for choosing us as your medical home.

Next Steps

1. Review the new patient folder, which contains valuable information about our services, hours of operation, tools to enhance your care, policies, and patient rights and responsibilities.

2. Complete all pages of this registration packet.

3. Complete the Records Release form so we may obtain your medical records from your previous provider and other specialists participating in your care. You must include each provider's full name, address, phone number, and fax number.

4. Complete the Eligibility Determination application if you need financial assistance through the Oregon Health Plan or our Sliding Discount Program. Make sure to include any required proof of income.

5. Return your completed paperwork to any of our registration staff. You will need to provide a copy of your insurance card or bring the card with you so we may make a copy.

6. If you need a dental provider, please let our New Patient Coordinator know when you turn in your packet.

7. Our New Patient Coordinator will contact you within (10) business days to review all the information in the new patient folder, answer any questions you may have, and schedule your first appointment.

Your Healthcare Team

Siskiyou Community Health Center (SCHC) is proud to be designated as a Patient-Centered Primary Care Home (PCPCH). This means that you are at the center of your care, and your needs, preferences, and goals are prioritized. Your care team will work with you to create a personalized care plan and coordinate with other healthcare providers to provide you with comprehensive, high-quality care.

At SCHC, you can expect the following:

- Your Primary Care Provider will coordinate your care and ensure you receive the necessary services when needed.
- The staff at SCHC will be attentive to your concerns and available to answer your questions.
- SCHC's care team will empower you to take an active role in your health.

You will be assigned a core care team which is a Primary Care Provider supported by two medical assistants and a nursing team, who will assist with your medical visits, provide clinical services, and handle phone calls and voicemails. We strive to respond to messages within 24 hours.

Siskiyou Community Health Center

In addition to your core medical care team, you will have access to an extended care team that includes:

- Walk-in clinic services
- Referral specialists
- Behavioral Health
- Dental
- Lab and Radiology
- Pharmacy
- Billing Specialists
- Outreach coordinators

You can learn more about our services by visiting our website at www.siskiyouhealthcenter.com.

Contact your Care Team

To schedule an appointment or to contact your care team during regular business hours, call us at (541) 472-4777 and follow the prompts to reach the appropriate care team member.

- To schedule an appointment, select '*Scheduling*'.
- To reach your medical team, select '*Other*' to be transferred to the operator.
- To request a prescription refill, please contact your pharmacy. If you use Siskiyou's pharmacy, you can select that from the main menu to be directed to our automated refill line. We also encourage you to use our pharmacy app, which allows you to manage your prescriptions on your mobile device.
- For questions about the status of a referral, select '*Referrals*.'

If you need medical assistance after regular business hours, call the same number to be connected with our answering service. You will then be promptly assisted by the RN Advice Line or a SCHC on-call provider as appropriate. For emergency situations, patients will be referred to the emergency room or to call 9-1-1.

We offer a walk-in clinic at both our Grants Pass and Cave Junction locations that provide in-person and virtual visits. No appointment is necessary. The Walk-In Clinic provides care for minor injuries, illness, prevention and screening services, and chronic conditions. Visit the Virtual Visit page on our website at www.siskiyouhealthcenter.com for more information or to schedule a walk-in clinic virtual visit.

How to Prepare for Your Appointments

1. Confirm your appointment. You will receive texts and/or emails starting one week before your appointment, allowing you to confirm your appointment and pre-register for your visit digitally. If you do not respond to these, our scheduling staff will call a couple of days before your appointment. ***If we do not hear from you by 3:00 PM the day before, your appointment will be canceled.***
2. Arrive 15 minutes before your appointment.
3. Bring your insurance card(s) and any copayment amount due.
4. For your first visit, bring all medications you currently take, both prescribed and over-the-counter, including supplements and vitamins.
5. Be prepared to share the specific healthcare concerns you want to address with your care team.

Siskiyou Community Health Center

How did you hear about us?

☐ Doctor Referral ☐ Friend/Family Referral ☐ Yellow Pages ☐ Social Media (please list app) _____

☐ Newspaper (please list publication) _____ ☐ Magazine (please list publication) _____

☐ Radio (please list station) _____ ☐ Google Search ☐ Billboard ☐ Other _____

1 Patient Demographics

Full Name _____ Nickname _____

SSN_____ Date of Birth_____ Birth Sex ☐Female ☐Male

Billing Address _____ City_____ State_____ Zip_____

Home Address _____ City_____ State_____ Zip_____

Home Phone _____ Day Phone _____ Cell Phone _____

Preferred Notification for Reminders ☐ Phone Call ☐ Text Message ☐ Opt Out (No Reminders)

Emergency Contact Name/Relationship _____ Phone_____

Marital Status ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐Domestic Partner

Primary Language ☐English ☐Spanish ☐Sign Language ☐Other_____Do you need an interpreter? ☐Yes ☐No

Name of Spouse/Significant

Other**_____

SSN_____ Date of Birth_____ Phone _____

If you would like this person to be able to discuss your medical care and/or billing issues, please request an Authorization Form.

Primary Pharmacy_____ Secondary Pharmacy _____

2 Insurance Information - Please provide your insurance card(s)

Name of Primary Insurance_____ Policy #_____

Policyholder Name_____ Date of Birth_____

Name of Secondary Insurance_____ Policy #_____

Policyholder Name_____ Date of Birth_____

3 Minor Patients Only

Mother's Name_____Date of Birth_____ SSN_____

Address_____ Phone_____

Father's Name_____ Date of Birth_____ SSN_____

Address_____ Phone_____

Siskiyou Community Health Center

4 Patient Statistics

As a Federally Qualified Health Center, we are able to offer services to all our patients, including the underserved, as a result of funding from Federal Grants. In order to receive grant dollars we are required to gather, on a yearly basis, statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

What is your living status? ☐Homeless ☐Not Homeless **Are you a Migrant Farm Worker?** ☐Yes ☐No

What is your Race? ☐White ☐American Indian/Alaska Native ☐Asian ☐Black/African American

(mark all that apply) ☐Native Hawaiian ☐Pacific Islander

What is your Ethnicity? ☐Not Hispanic/Latino ☐Hispanic/Latino **Are you a Veteran?** ☐Yes ☐No

Gender Identity? ☐Declined ☐Female ☐Male ☐Transgender F to M ☐Transgender M to F ☐Genderqueer ☐Other

Sexual Orientation? ☐Declined ☐Straight/Heterosexual ☐Lesbian/Gay ☐Bisexual ☐Something Else ☐Don't know

What is your Gross Annual Household Income? _____ **How many people are in your household?** _____

What is your employment status? ☐Employed ☐Homemaker ☐Retired ☐Student ☐Unemployed ☐ Disabled

If over age 18, what is the highest grade in school you completed? ☐Elementary ☐6th ☐7th ☐8th ☐9th ☐10th ☐11th ☐12th

☐GED ☐Attended College ☐ Associate's Degree ☐Bachelor's Degree ☐Master's Degree

5 Billing and Collection Policy

Payments of copays, deductibles and any other amount not covered by insurance is expected at the time of service. Any amount not received at your appointment will be billed on your monthly statement. All statements are due in full upon receipt unless prior financial arrangements have been made. Unpaid balances will be subject to our collection process, which may include assignment to an outside collection agency and possible discharge from the practice.

We will submit a claim to all contracted primary and secondary insurance companies with the exception of motor vehicle claims and out-of-state worker's compensation claims. It is your responsibility to supply us with a current copy of your insurance card(s) at each appointment. We do offer a sliding fee discount based on your income and family size. Please ask our front desk staff for an application.

The Billing Office is open Monday through Friday, 8:00 am to 5:00 pm. We accept all major debit/credit cards, checks, and cash. We also accept Care Credit at our Dental facility. A $29 NSF fee will be applied for all returned checks.

I hereby authorize Siskiyou Community Health Center to provide services to the above named patient and to use and release medical or dental information as required for treatment, payment and health care or dental operations. I also assign Siskiyou Community Health Center payments to which I'm entitled for medical, surgical, behavioral health and dental expenses. I have read and understand the above policy regarding my financial responsibility for all services provided whether covered by insurance or not.

_____ _____

Patient or Patient Representative Signature **Date**

6 No Show Policy

An appointment that is not kept, not canceled 24 hours in advance, or is late is called a "No-Show". If you are unable to be at your appointment, it is your responsibility to call and reschedule or cancel the appointment.

New Patients–Failure to confirm or cancel your new patient appointment at least 24 hours prior to the appointment time will result in a "no-show" status. New patients that fail to provide appropriate cancellation notice for two (2) appointments will no longer be eligible to establish care with us for twelve (12) consectutive months.

Established Patients - If an established patient "No-Shows" four (4) times, they will be notified that they are no longer eligible to schedule future appointments and will be seen in the clinic on a *same day basis* only.

I have read and understand this "No-Show" policy.

_____ _____

Patient or Patient Representative Signature **Date**

Siskiyou Community Health Center

Authorization to Exchange Verbal Health Information

Patient Information: *(Please print)*

Name: _____ Date of Birth: _____ /_____ /_____

Exchange Verbal Information To:

Name: _____ Date of Birth: _____ /_____ /_____

Relationship: _____

Information To Be Disclosed:

Initial all that apply.

_____ Medical Chart Notes	_____ Hospital Reports	_____ Dental Chart Notes
_____ Diagnostic Results	_____ Immunization	_____ Perio Chart
_____ Lab/Pathology	_____ Specialist Consults	_____ Radiographs
_____ Medication/Pharmacy	_____ Billing	_____ Appointment info.

This authorization may be revoked at any time by notifying a Siskiyou Community Health Center staff member. Such notice will be effective immediately upon receipt by Siskiyou Community Health Center records personnel. This consent will be **valid up to one (1) year.**

Date consent begins: _____ Date consent expires: _____

Signature: _____ Date: _____

I recognize that the information discussed may contain information that is protected by federal and state laws (i.e. Drug/Alcohol Abuse, Mental Health, HIV/AIDS), and I specifically consent to the disclosure of such information.

Initial each one that applies:

_____ HIV/AIDS
_____ Mental Health
_____ Drug/Alcohol Abuse

Signature: _____ Date: _____

Siskiyou Community Health Center

Notice: Patient Privacy

We are required by law to protect the privacy of your medical information and to provide you with written Notice describing:

How Medical Information About You May Be Used and Disclosed and How You Can Access This Information

- We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

- We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

- As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

- We have available a detailed **NOTICE OF PRIVACY PRACTICES** which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the bottom right hand side of this page indicates the date of the most current NOTICE in effect.

- You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

- If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact the HIPAA Privacy Officer at 1-866-667-2870.

Siskiyou Community Health Center

Acknowledgment and Consent

I understand that Siskiyou Community Health Center (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice. It may be in the form of written or electronic records or spoken words and may contain information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.
I understand and agree that This Practice may **use and disclose** my health information to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment;
- Determine my eligibility for a health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible for paying some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception areas.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received or been offered a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient Signature)

Print Name: _____ Date of Birth: _____
(Patient Name)

By: _____ Date: _____
(Patient Representative Signature)

Print Name: _____
(Patient Representative Name)

Description of Representative's Authority: _____

Siskiyou Community Health Center

Grants Pass Medical
1701 NW Hawthorne Avenue
Grants Pass, OR 97526
(541) 471-3455

Cave Junction Medical
25647 Redwood Highway
Cave Junction, OR 97523
(541) 592-4111

New Patient Adult Health History

This form must be completed in full, including all dates.

Patient Name: *(Please print)* _____ Date of Birth: _____

Primary Care Provider: _____ Today's Date: _____

Medical History

List Medical Condition(s)	Current? Y/N	Date Diagnosed	Provider Seen	Office Use

Allergies

☐ No Allergies

Name	Reaction	Name	Reaction
1.		3.	
2.		4.	

Medication(s) (*Including over the counter, herbal supplements and vitamins)*

Name Of Medication	Current? Y/N	Prescribed By

Siskiyou Community Health Center

New Patient Adult Health History (Page 2 Of 3)

This Form Must Be Completed In Full, Including All Dates.

Patient Name: *(Please Print)* _____ Date Of Birth: _____

Surgical History (*Please include year of surgery)*

SURGICAL PROCEDURE	DATE	PHYSICIAN

Health Maintenance

Last Colonoscopy	
Last Tetanus Vaccine	
Last Pneumonia Vaccine	

Women's Health History

Age Menses Started		**Total Pregnancies**		**# Ectopic or Tubal Pregnancies**	
Age of First Birth		**# Full Term**		**# Live Births – Vaginal Delivery**	
Age / Year Menopause *(if applicable)*		**# Pre-Term**		**# Live Births – Cesarean Section**	
Last PAP		**# Miscarriages**		**# Children Living Now**	
Last Mammogram		**# Abortions**			

Family Health History *Have any of your relatives had any of the following?*

DIAGNOSIS	CHECK ALL THAT APPLY	RELATIONSHIP	LIVING
ADD / ADHD			
Alcoholism			
Allergies			
Alzheimer's Disease			
Arthritis			
Asthma			
Bipolar Disorder			
Birth Defects Type: _____			
Blood Disease			
Cancer Type: _____			
CVA (Stroke)			
Depression			
Developmental Delay			
Diabetes			
Eczema			

DIAGNOSIS	CHECK ALL THAT APPLY	RELATIONSHIP	LIVING
Heart Disease			
High Cholesterol			
High Blood Pressure			
Learning Disability			
Lung Disease			
Mental Illness			
Migraines			
Obesity			
Osteoporosis			
Renal Disease			
Seizure Disorder			
Thyroid Disease			
Other:			
Other:			
Other:			

Siskiyou Community Health Center

New Patient Adult Health History (Page 3 Of 3)

This Form Must Be Completed In Full, Including All Dates.

Patient Name: *(Please Print)* _____ Date Of Birth: _____

Social History

Education / Military Experience

High School Graduate or GED Equivalent:

☐ Yes ☐ No

College:

☐ Some ☐ Degree Obtained? _____

Military Experience: _____

Employment

Employer: _____

Occupation: _____

Part-time Full-time Retired Disabled

(Circle one)

Tobacco

Do you use tobacco? ☐ Yes ☐ No ☐ Former Year Quit: _____

Type: _____ How much? _____

Number of Years: _____

Previous Tobacco Cessation Attempts? ☐ Yes ☐ No Method: _____

Passive Smoke Exposure? ☐ Yes ☐ No

Alcohol

Do you drink alcohol?

☐ Yes ☐ No ☐ Former Number of Years: _____

Type: _____

How much? _____

How often? ☐ Daily ☐ Weekly ☐ Socially ☐ Binge

(Check one)

Recreational Drugs

☐ Yes ☐ No ☐ Former Number of Years: _____

Type: _____

How much? _____

How often? _____

Caffeine

☐ Yes ☐ No

Type: _____

How much? _____

How often? _____

Lifestyle

Activity Level (Example: Sedentary, Moderate, Athletic): _____

How many hours per week do you exercise? _____

Home Environment / Safety

Home Heating Type:

_____

Dental Provider: _____ Last Exam: _____

☐ SCHC Provider ☐ Other ☐ None

Advanced Directives in Place: ☐ None ☐ Living Will ☐ Durable Power of Attorney ☐ Health Care Proxy

Siskiyou Community Health Center

Mission Statement

Identify and provide care for primary health needs of our community in a professional and compassionate manner.

Patient Rights and Responsibilities

At Siskiyou Community Health Center, we recognize the importance of treating each patient with respect and dignity, of recognizing individuality, of providing clear information and involving the patient in choices about his or her care and treatment.

Patient Rights

As a patient, you have the right to:

Quality of Care

- Care which recognizes and maintains your dignity and values.
- Care, treatment and services that are within the scope and mission of Siskiyou Community Health Center and in compliance with law and regulation.
- A safe care setting.
- Care provided by competent personnel.
- Knowing the identity and professional status of your caregivers.
- Respect for your cultural, psychosocial, spiritual and personal values, beliefs and preferences.
- Free qualified interpreters and/or special equipment to assist language needs.
- Meaningful accessibility for individuals with disabilities.
- Free aids to meaningful accessibility for individuals with disabilities to communicate effectively.
- Information about care options.
- Freedom from all forms of abuse and harassment.
- Transport services to access health center care.

Confidentiality and Privacy

- Personal privacy within the law.
- Confidentiality of your health care and billing records.

Decision Making

- To receive all health care information regarding health status, including alternatives and risks.
- To help plan your care, treatment, and services.
- To participate in decisions about your care, treatment and services.
- To give informed consent prior to the start of any tests, surgery, procedure or treatment. You may also withdraw your consent at any time.
- To request a second opinion.
- To create advance directives (such as a living will) and to have the intent of such directives honored to the extent permitted by law.
- To have a surrogate decision maker, as allowed by law, when you are not able to make decisions about your care, treatment, and service.
- To choose or change your health care provider.

Siskiyou Community Health Center

Access to Medical Records

- To ask to review your medical records with your health care provider and to have the information explained and interpreted, request amendment to, and receive an accounting of disclosures regarding you own health information as permitted under applicable law within a reasonable time frame.

Seclusion and Restraints

- To be free of any sort of restraint unless medically necessary.

Grievance Process

- To voice a complaint to your health care provider without fear of reprisal.
- To receive a timely response with the results of your complaint.
- To request an administrative consultation and/or participate in any discussions that arise in the course of your care.
- To communicate concerns by calling 541-471-3455 and ask to speak with the Chief Operations/Adminstrative Officer.
- To file a complaint or grievance with the Chief Compliance Officer 541-472-4713.
- To file a grievance appeal with the Chief Compliance Officer 541-472-4713.

If not resolved, file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights. Forms are available at https://www.hhs.gov/ocr/filing-with-ocr/index.html.

Billing

- A complete explanation of your bill.
- To speak with a billing specialist regarding your bill, insurance, co-pays and other means of payment.
- To communicate with a billing specialist call 541-472-4799.

Non-Discrimination

This health care facility makes its services available to all individuals in the community.

Nondiscrimination Statement: Siskiyou Community Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, religion, sexual orientation, and inability to pay.

This health care facility does not discriminate against a patient because of age, gender, including discrimination based on pregnancy, disability, race, creed, color, national origin, or because of a patient's coverage of health insurance in Marketplaces and other health plans. If you believe you have been improperly denied services, contact the clinic manager for your location:

- Grants Pass Clinic Manager – (541) 471-3455
- Cave Junction Clinic Manager – (541) 592-4111
- Dental Clinic Manager – (541) 479-6393
- Outreach Program Manager – (541) 472-4743
- Walk In Clinic Manager – (541) 472-4705

Siskiyou Community Health Center

Non-Discrimination (cont.)

If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Siskiyou Community Health Center Compliance Officer, or:

- Electronically through the Office for Civil Rights Complaint Portal, at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
- By mail at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
- By phone at The Department of Health and Human Services, Office for Civil Rights toll-free
- at: 1-800-368-1019, TDD: 1-800-537-7697.

Patient Responsibilities

Help us take care of you. Please know that we support you in meeting your responsibilities during your stay, such as:

Sharing Information

- Providing accurate and complete medical information to your health care providers.
- Understanding your treatment plan, asking questions, and informing staff when answers are not understandable or your treatment plan cannot be followed.
- Reporting any change in your condition.
- Informing us of Advance Directives.

Involvement

- Participating in your care.
- Following the advice of your health care team to the best of your ability.
- Accepting the consequences of your decisions if you refuse to follow recommended treatments and instructions.

Respect and Consideration

- Respecting the needs, rights and property of other patients, family members and caregivers.
- Being mindful of noise levels.
- Refraining from all forms of abuse and harassment.

Insurance and Billing

- Knowing the extent of your insurance coverage.
- Knowing your insurance requirements such as pre-authorization, deductibles and co-payments.
- Calling the billing office with questions or concerns.
- Meeting your financial obligations.

Siskiyou Community Health Center is a weapons, tobacco and drug abuse-free zone.
This institution is an equal opportunity provider and employer.

Siskiyou Community Health Center

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Healthcare Provider to ***Release*** Information: Person/Agency to ***Receive*** Information: ☐ **Patient/Self**

Name	
Mailing Address	
Phone	**Fax**

☐ **Name**
Siskiyou Community Health Center (SCHC)
1701 NW Hawthorne Ave, Grants Pass OR 97526
PH: 541-471-3455 FAX: 541-471-1439

☐ **Name**
Siskiyou Community Health Center (SCHC)
PO Box 1850, Cave Junction OR 97523
PH: 541-592-4111 FAX: 541-592-3916

PURPOSE OF THE DISCLOSURE _____ Transfer of Care _____ Coordination of Care _____ Other _____

DATES REQUESTED _____ **ALL** Dates of Service **OR** Date Range: From _____ To _____

INFORMATION REQUESTED (**Must initial each item requested**):

_____ Initial here to include **ALL** types of records indicated below **OR** initial the specific records requested

_____ Chart Notes	_____ Specialist Consults	_____ Immunization Records
_____ Lab Results	_____ Hospital Records	_____ Billing Statements
_____ Radiology and Imaging Reports	_____ Physical Therapy Notes	
_____ EKG Reports	_____ Other _____	

SPECIFIC CONSENT (**By initialing the space(s) below, I am specifically authorizing the release of the specified confidential information**):

_____ Records regarding mental illness or developmental disability*	_____ Communicable Disease
_____ Medical Records relating to alcohol and/or drug abuse	_____ Venereal Disease
_____ HIV Test Results	_____ Child Abuse and Neglect
_____ Genetic Testing information and results	_____ Sexual Assault

EFFECTIVE DATE OF AUTHORIZATION

_____ Until the purpose is fulfilled

_____ Other _____

I understand that I may revoke this Authorization in writing at any time by notifying the Medical Records Department. I understand that once my health information is disclosed to the recipient, SCHC cannot guarantee that the recipient will not re-disclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws. I understand that I may refuse to sign this Authorization, and if I do refuse, my ability to obtain treatment will not be affected.

I have read and understood this authorization and had a chance to ask questions about the disclosure of the health information. I authorize SCHC to use/disclose my health information in the manner described above.

_____

Signature of Patient or Personal Authorized by Law **Date**

_____

***Name and Signature of Witness** *(required for release of information about mental illness or Developmental disability)* **Date**

Staff Initials_____

Siskiyou Community Health Center

Financial Assistance

Do you need help paying for healthcare?

Complete the attached application and return it to any of our registration staff to see if you qualify.

Oregon Health Plan (OHP)

A state-funded Medicaid program that provides no-cost insurance to eligible individuals. We have staff available to assist patients with applications.

OHP benefits can be used for covered services provided at any participating facility, not just services at Siskiyou Community Health Center.

Sliding Fee Discount Program

Provides discounts on services to qualified individuals based on their ability to pay. Your discount is determined by your family size and income. This program covers all services provided at Siskiyou Community Health Center.

If you have any questions about the Oregon Health Plan, please call our Eligibility Specialists at (541) 472-4761.

Siskiyou Community Health Center

Frequently Asked Questions

What is the Sliding Fee Discount Program (Slide Program)?

A federal program that allows us to offer discounts on our services to patients who may not have the ability to pay full fees. Eligibility is based on your family size and income.

Who can apply?

All patients, even those with insurance, including Medicare, Oregon Health Plan, and/or private insurance. Applying for the Slide Program has no impact on your current insurance coverage.

Who is included in the household?

You, your spouse, children you claim as a dependent, your live-in partner (if you have children together), and anyone else you include on your federal tax return, even if they do not live with you. A copy of your federal tax return will be required as proof of dependents if individuals other than your spouse and children under 18 are indicated.

What does the Slide Program cover?

All services at Siskiyou Community Health Center, including medical services, in-office procedures, dental care, pharmacy, and in-house lab and x-ray.

If I already have insurance, why would I need the Slide Program?

While your insurance may cover many of the services you receive, the Slide Program may be able to help with the balance due after insurance pays, such as copays, coinsurance, or deductible amounts. It may also help reduce the cost of services your insurance may not cover, such as labs, pharmacy, or dental care.

How do I apply?

Complete the Eligibility Determination application and submit proof of income for every adult listed in the household. Once your application is approved, it will be ***valid for one year*** unless your financial situation changes. A new application and proof of income will be required after one year to continue to be considered for the slide program.

What do I need to bring as proof of income?

- **Currently Employed -** A copy of your most current month's worth of pay stubs. If you are paid monthly, you will need to bring 2 month's worth.
- **Self Employed -** A copy of your most recent federal tax return, including the signature page.
- **Unemployed -** Documentation that indicates your weekly benefit amount before taxes.
- **Social Security Disability or Social Security Retirement Letter -** A SSA-1099 will not be accepted.
- **Worker's Compensation Letter**
- **Child or Alimony Support –** a copy of the court order showing the monthly amount received.
- **No Income** – If an adult in the household does not work or is not receiving any income, an Unable to Provide Documentation of Income form will need to be completed.

OFFICE USE ONLY:
☐Slide Only
☐OHP Only
☐Slide & OHP

SISKIYOU COMMUNITY HEALTH CENTER
Eligibility Determination Application

1 PRIMARY CONTACT INFORMATION

Full Name ______________________________ DOB _______________ Phone ____________________

Home Address (include City, State, Zip)____

Mailing Address (if different)____

2 HOUSEHOLD MEMBERS

This includes you, your spouse, your children (*any you claim as a dependent on your taxes*), your live-in partner (*if you have children together*) and anyone else you include on your federal income tax return, even if they do not live with you. A copy of your current federal income tax return will be required as proof of dependents if individuals, other than your spouse and children under 18, are indicated.

FULL NAME	RELATIONSHIP	DOB	CURRENT INSURANCE?	EMPLOYED?	Office Use Only
	SELF		☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No

3 ANNUAL HOUSEHOLD INCOME

Please answer ALL of the following questions.

Do you, or anyone in your household, receive:

Social Security or Disability? ☐Yes ☐No
Unemployment Benefits? ☐Yes ☐No
Pension/Retirement payments? ☐Yes ☐No
Child/Alimony Support? ☐Yes ☐No

Indicate all income received for household members in the appropriate boxes below. The income amount should be listed as the **gross (before taxes) MONTHLY amount**. Proof of income is required.

INCOME SOURCE	List ALL monthly income. If no income, enter 0.	If working, list the name of your employer
SELF		
SPOUSE		
ALL DEPENDENTS		
TOTAL		

4 REQUIRED DOCUMENTATION

In order for Siskiyou to help determine your eligibility, you must provide the following documents:

- ✓ Proof of income (all household members 18+)
- ✓ Current tax return if household includes individuals other than spouse and dependents under 18.

Acceptable proof of income includes:

- ➢ Pay stubs for the last 30 days (60 days if paid monthly) - required if employed.
- ➢ Social Security/SSI Award Letter (1099-S is not accepted)
- ➢ Federal tax return (required for self employed)
- ➢ Disability Award Letter
- ➢ Unemployment Documentation (must show the gross weekly amount)
- ➢ Child/Alimony Support documentation.

If any adult household member does not have income, an ***Unable to Provide Documentation of Income form*** may be completed. See our Eligibility Specialist to determine if your situation qualifies for use of this form.

5 SIGNATURE

I understand that the information I provided will be used to determine my ability to pay. I certify that the information given is accurate and complete to the best of my knowledge. In the event of a change in income, I will notify the facility. I understand that I may be responsible for the cost of all or part of my care and that I will be expected to pay this portion at the time of service.

Signature_____ **Date** _____

6 OREGON HEALTH PLAN (OHP) QUESTIONNAIRE

Are you 65 or older? ☐Yes ☐No
Do you have Medicare? ☐Yes ☐No
Do you have OHP? ☐Yes ☐No

STOP: if you answered **'Yes'** to **ANY** of the above questions.

GO: if you answered **'No'** to **ALL** of the above 3 questions.
Complete this questionnaire to help us determine if you may qualify for OHP.

1. What is your tax filing status? ☐SINGLE ☐ MARRIED-J ☐ MARRIED-S ☐ NOT FILING
2. Are you a US Citizen, US National or Qualified Non-Citizen? ☐Yes ☐No
3. Do you live in Oregon and intend on staying in the state? ☐Yes ☐No
4. Has anyone on this application been incarcerated in the past 90 days? ☐Yes ☐No
   If yes, list person name, facility and in date/out date_____

If you answer ***YES*** to any of the following questions, please indicate the name of the individual(s) on the line provided.

5. Is anyone in your household pregnant? ☐Yes ☐No _____
6. Is anyone a Tribal Member? ☐Yes ☐No _____
7. Eligible for or receive Indian Health Services ☐ Yes ☐No _____
8. Is anyone legally blind? ☐Yes ☐No _____
9. Is anyone permanently disabled? ☐Yes ☐No _____
10. Does anyone receive Medicare or SSI? ☐Yes ☐No _____
11. Does anyone have unpaid medical bills from the past 90 days? ☐Yes ☐No _____
12. Is anyone 18 years old and a full-time high school student? ☐Yes ☐No _____
13. Was anyone receiving foster care in OR at age 18? ☐Yes ☐No _____
14. Does anyone have current health insurance? ☐Yes ☐No _____
15. Has anyone lost healthcare coverage in the past 90 days? ☐Yes ☐No _____

To allow our Eligibility Specialist to submit an OHP application for you, the OHP application consent forms must be completed. These are available at our Registration desks or online at https://apps.state.or.us/Forms/Served/he7210.pdf.

ADDITIONAL HOUSEHOLD INFORMATION (SSN are required for OHP)

Primary Contact Email :_____ Preferred Language:_____

NAME	GENDER	SSN

FOR OFFICE USE ONLY

OHP ELIGIBILITY

OHP Questionnaire: ☐Patient is 65 or older and/or has Medicare ☐Patient already has OHP

☐Patient Declined - Reason:_____

☐Patient did not complete

Were OHP consent forms signed? ☐Yes ☐No

PROVISIONAL SLIDE DETERMINATION

Date Provisional Slide Used _____ **SCHC Initials** _____

If the Provisional slide is being used for today's application, indicate the family size/income estimated from the application and the discount amount. If the Provisional slide was previously used, leave the below lines blank.

Income Determination from application _____ Family **Size from application** _____

Provisional Slide Discount **A** **B** **C** **D** **NONE**

ANNUAL INCOME CALCULATION

Proof Received:

☐Pay Stubs
☐ Social Security/Disability Award Letter
☐ Unemployment Documentation
☐Federal Tax Return
☐ Child/Alimony Support
☐ Unable to Provide Documentation Form
☐Other _____

Income Calculation

DOCUMENTATION RECEIVED/DETERMINATION

Family Size (#): _____ Documented Family Annual Income: $_____

Qualifies for Slide: ☐Yes ☐No Effective Date:_____ Exp Date:_____

Discount Category (circle): **A** **B** **C** **D**

If not qualified, why?_____

_____ _____

SCHC Staff Printed Name **Date**