For Office Use Only:	Circle One:	Intake or Renewal:	MCD	MCR	Private	Slide Fee	Patient #: _____

Today's Date:_____

HealthLinc
YOUR COMMUNITY HEALTH CENTER®

Patient Legal Name:	Date of Birth:
Patient Preferred Name:	Social Security:
Address:	Telephone:
City: State: Zip code:	Township/County:
Email address:	US Resident: Y / N Veteran: Y / N
Emergency Contact: Relationship:	Telephone:

List all individuals living in household (list each separately, INCLUDING THE PATIENT):

Name	M/F	Age	Date of Birth	Relation	SSN

Gender Identity	
Male	
Female	
Transgender Male/Female-to-Male	
Transgender Female/Male-to-Female	
Other	
Declined to answer	

Sexual Orientation	
Straight	
Gay	
Lesbian	
Bisexual	
Other	
Unknown	
Declined to answer	

Homeless	
Homeless Shelter	
Transitional	
Doubling Up	
Street	
Other	
Unknown	

Primary Language	
English	
Spanish	
Other	
Do you need an interpreter?	

Marital Status	
Single	
Married	
Separated	
Divorced	
Widowed	

Employment	
Full Time	
Part Time	
Self-Employed	
Retired	
Seasonal	
Unemployed	

Race	
Black/African-American	
Asian	
Native Hawaiian	
Other Pacific Islander	
American Indian/Alaskan National	
White	
More than one race	
Refused	

Ethnicity				
Are you Hispanic/Latino?	Yes		No	

Preferred Communication Method					
Text		Email		Voice	

Monthly Household Income	
None	$
Wages-Gross	$
Disability	$
Unemployment	$
Social Security	$
Workman's Comp	$
Monthly Total	$
Annual Total	$

Annual Household Income	
$0-20,000	
20,001-50,000	
50,001-100,000	
100,001+	

Insurance	
Patient Refused Intake	
Uninsured	
Medicare	
Medicaid	
Medicaid Pending	
HIP	
Private Insurance	

Preferred Pharmacy
Address:

It is my responsibility to keep HealthLinc informed of any change in address, phone number, income, and/or health coverage.

I understand that the information which I submit is subject to verification by HealthLinc, federal and/or state enforcement agencies, and others as required. Under penalty of perjury and/or fraud, I affirm that the above information is true and correct.

_____ _____

Applicant (signature) ***Applicant*** (printed name)

(The section below is for Office Use Only)

Proof of Income Provided (circle one): Yes No Medical Slide Fee_____Dental Slide Fee _____Renewal Due ____Entered ____Date:____Scanned:___

HealthLinc
YOUR COMMUNITY HEALTH CENTER®

Mobile School-Based Health Center Dental

Patient Legal Name: _____

☐	Yes	☐	No	Is your child allergic to latex?
☐	Yes	☐	No	Has your child ever been examined by a dentist?
☐	Yes	☐	No	Does your child have asthma?
☐	Yes	☐	No	Has your child had fluoridated water since birth?

Briefly explain health problems and/ or list medications your child is taking: _____

_____

CONSENT FOR TREATMENT – SIGNATURE REQUIRED

Please return this form with a YES OR NO response within 3 days.

I give HealthLinc permission to provide dental services for my child, to collect payment from Medicaid, Hoosier Healthwise or insurance on my behalf, and to allow the nurse and a dentist of my choice to obtain my child's dental record from this examination. Treatment may include dental examination, sealants, x-rays, fluoride treatment and/ or temporary fillings. I understand that if my child is not enrolled in Medicaid/ Hoosier Healthwise, a fee will be charged based on my statement of ability to pay. By signing below, I am indicating that I have read and understand the contents of the cover letter accompanying this consent form, that I understand the terms of the consent agreement and that I have the legal authority to give this consent for the child. This consent is valid for 24 months.

REQUIRED: ☐ **YES,** I do consent ☐ **NO,** I do not consent

Signature: _____ **Date:** _____

CONSENT FOR YOUR CHILD'S PARTICIPATION IN PHOTOGRAPHY OR MEDIA COVERAGE
(Signature Optional)

Activities associated with HealthLinc are frequently highlighted by both Healthlinc and the community. By giving your consent, you permit HealthLinc to have the exclusive right to use, and authorize others to use, your child's image or voice for interviews and photographs for the purpose of news, publicity, or HealthLinc promotion and advertising in print and electronic formats. Furthermore, you consent to members of the media, which may include television stations, newspapers, radio stations, and others, to photograph or interview your child to fulfill journalistic needs.

☐ I AGREE to allow my child to participate in media and promotional coverage of Media activities.

☐ I DO NOT AGREE to allow my child to participate in media and promotional coverage of Media activities.

Signature: _____ **Date:** _____

Mobile School-Based Health Center Dental

PAYMENT INFORMATION

Medicaid Information (Medicaid/ Hoosier Healthwise covers 100% of the cost)
If possible, please attached a photograph of the Medicaid Card.

Child's 12-digit Medicaid Recipient ID ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

If your child is enrolled in Medicaid or Hoosier Healthwise but has other insurance that must be used first, you must fill out the section below:

Insurance Company: _____Group Number: _____

Employer: _____Name of Insured: _____

Date of Birth: _____ ID#: _____Relationship to Child: _____

NO MEDICAID OR HOOSIER HEALTHWISE?

☐ **I will expect to receive a bill for my child's dental treatment, according to my annual income level checked below:**
(If unchecked, middle category will be used to determine the fee. (See Fee Chart below which indicates highest fee possible.)

☐ More than $ 36,000 ☐ $28,000 - $36,000 ☐ $23,000 - $27,999 ☐ $18,000 - $22,999 ☐ Less than $ 18,000

☐ Please send information about Hoosier Healthwise – free

☐ I am unable to pay the fees and request free preventive care and sealants for my child.

Medicaid or Hoosier Healthwise pays 100%. No Charge to the family. For information about free dental and medical Insurance for children, call Indiana Hoosier Healthwise 1-800-889-9949.

Without Medicaid or Hoosier Healthwise, fee will be charged according to family income and services provided.

Sliding Fee Scale

We will charge persons receiving health services at the usual and customary rate prevailing in this area. Health services will be provided at a reduced charge to persons unable to pay for services. In addition, persons will be charged for services to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.

We will not discriminate against any person receiving health services because of their inability to pay for services, or because payment of the health services will be made under Part A or B of the Title XVIII ("Medicare") or the Title XIX ("Medicaid") of the Social Security Act.

The determination of qualification is based on the number of members in the household and the following information:

(Any of these items will be accepted):

- Most recent tax filing with the IRS and/or W2's from employer(s).
- A copy of Social Security or Disability Award letter(s) or unemployment statement(s).
- Pay stubs from all employers for the last 30-day period.
- If unemployed, no income and living with others, we require a signed and dated letter from the person providing support of the patient.
- Driver's license or state ID card.
- Marketplace income verification.