Mountain Community Health

61 Pine Street
Bristol, VT
Phone (802) 453-5028 Fax (802) 453-6105

Patient Registration Form

Name: (First) _____(Middle)_____(Last)_____

Date of Birth: _____/_____/_____ **Previous Name** (if applicable): _____

Mailing Address: _____

Physical Address (if different than above): _____

Home Phone: ( )_____ **Cell Phone**: ( )_____ **Work Phone**: : ( )_____

How would you like us to remind you of appointments: ☐ Phone (preferred #) _____ ☐ Text

Social Security # _____-_____-_____ **E-mail**:_____

Would you like access to our online Patient Portal: ☐ Yes ☐No **Primary Care Provider:** _____

Emergency Contact: _____**Phone**: _____**Relationship:** _____

Sexual Orientation: ☐ Lesbian ☐ Gay ☐ Straight ☐ Bi-sexual ☐ Other ☐ Chose not to disclose Sexual Orientation

Gender: ☐ Male ☐ Female ☐ Transgender Male/Female to Male ☐ Transgender Female/Male to Female

☐ Choose not to disclose Gender

Sex at Birth: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partner ☐ Widowed ☐ Legally Separated

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐Military ☐ Unemployed

Student Status: ☐ Full-time Student ☐ Part-time Student ☐ Not a Student

Employer Name and Address: _____

Pharmacy Name and Location: _____ **Mail Order Pharmacy:** _____

Responsible Party Information (Who is Responsible for Paying the Bill) – Complete Only if Not Same as Patient:

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian (Proof of legal status required for treatment)

Name: (First) _____(Middle)_____(Last)_____

Date of Birth: _____/_____/_____ **Previous Name** (if applicable): _____

Mailing Address: _____

Physical Address (if different than above): _____

Home Phone: ( )_____ **Cell Phone:** ( )_____**Work Phone:** ( )_____

☐ **I do not have Medical Insurance** ☐ **I would like to apply for the Sliding Fee Scale Discount**

Primary Medical Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

Secondary Medical Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

Primary Dental Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

Secondary Dental Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

MCH is a Federally Qualified Health Center, and we are required to collect the following information:

Are you a Seasonal Worker? ☐ Yes ☐ No

Are you a Migrant Worker? ☐ Yes ☐ No

Are you a United States Veteran? ☐ Yes ☐ No

Are you Homeless? ☐ Yes ☐ No

If yes, ☐ Homeless ☐ Shelter ☐ Transitional ☐ Double up ☐ Street ☐ Other _____

How many people currently live in your household (including yourself): _____

Annual Household Income:_____ ☐ Choose to not disclose Income

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other _____ **Interpreter Needed?** ☐ Yes ☐ No

Race: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
☐ Other Pacific Islander ☐ Guamanian/Chamorro ☐ Samoan ☐ Black/African American
☐ American Indian/Alaska Native ☐ White ☐ More than one Race ☐ Choose not to disclose Race

Ethnicity: ☐ Mexican/Mexican American/Chicano ☐ Puerto Rican ☐ Another Hispanic Latino/a or Spanish
☐ Not-Hispanic/Latino/a or Spanish ☐ Choose not to Disclose Ethnicity

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☐ I have read the Notice of Privacy Practices for Mountain Community Health

☐ I have declined to read the Notice of Privacy Practices for Mountain Community Health. I am aware that there is a copy posted in the office.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Print Patient/Guardian Name Relationship to Patient

Mountain Community Health

Sliding Fee Discount Program Q & A Sheet

What is a sliding fee program?
A program designed to reduce the cost of medical and dental care here at Mountain Community Health (MCH) for those who meet income requirements. These discounts are available to patients based on the guidelines provided annually by the federal government.

How would I benefit from the sliding fee program?
If you qualify, medical and/or dental services provided at MCH may be substantially discounted.

What is covered under the sliding fee scale?
Medical and dental services are covered under the sliding fee scale program. Medical services provided "in-house" are eligible for a sliding fee discount. "In-house" refers to medical services provided at the clinic such as labs, x-rays, EKGs, immunizations, and office visits. Any specialty visits or diagnostics sent out to labs or hospitals are not covered under the sliding fee program. Advanced dental services, including but not limited to crowns, denatures and implants are not covered. Our staff is committed to helping you with determining what services are allowed under the sliding fee program and your questions are always welcome.

I would like more information on your sliding fee program. How do I apply?
You will need to submit a confidential application and provide proof of total household income. We have applications available on-site or on the Mountain Community Health Centers website: www.mchvt.org.

What are acceptable forms of proof of income?
Acceptable forms of income include your most recent income tax return, a copy of your social security benefits letter, or 2 recent pay stubs (from all working members of the household.) Please refer to the sliding fee discount program form for a more comprehensive list or if you have further questions speak to one of our MCH staff members.

Can I leave blanks on the application?
No, it is a requirement to complete the entire form.

My income has changed recently. Can I reapply for the sliding fee program?
Yes, we ask that you reapply anytime there is a change in your household income.

It appears that I will qualify for sliding fee but I have insurance. Can I still apply?
Yes. Patients may apply whether or not they have other insurance coverage. If you are approved, the program can help with any remaining balance after insurance has been applied.

I do not have a Medicare supplement. Would I be eligible for sliding fee?
Yes, you may be eligible for sliding fee. You will need to fill out an application and provide proof of income to be considered for the program.

Do I have to include all members of my household on the application?
Yes. All members living in the same household that is listed on your income tax return are considered "household members" and must be listed on your application. Roommates who share mutual living expenses are not considered to be members of the same household.

I have no income. How do you calculate my eligibility?
Complete the entire application, check the box on the form that looks like below, and a MCH staff member will be in contact with you if there are any further questions.

☐ **I attest that all members of my household have NO INCOME**

Mountain Community Health

I have a 19-year-old child living in my house with no source of income. Do I need to include him on the sliding fee application?
Yes, if this child is listed as a dependent on your tax return.

I am a full-time college student. Can I apply on my own?
Yes, if you are not a dependent on someone else's Income Tax Form. Otherwise, the person or persons that have listed you as a dependent should apply for you.

My only source of income is social security, but it is directly deposited in my bank. How can I show proof of income?
A copy of your social security award letter or a copy of your bank deposit statement showing your is an acceptable form of proof of income.

I am unable to pay the nominal fee today. Do I need to reschedule?
No, it is not necessary to reschedule. As a Federally Qualified Health Center we see patients regardless of their ability to pay. Any out-of-pocket balances will be billed to you.

I think I might qualify for a sliding fee discount. If I complete the sliding fee application, will it cover my visit today?
Yes, if the application is received at our office within 6 months from today's visit. Discounts will be applied retroactively on all approved applications for the 6-month period and through September 30th.

I have completed the application and provided proof of income. Now what?
You can mail the completed application to the address listed on the form or drop it off at MCH. Typically, applications are reviewed within 3-5 days of receipt. You will receive a letter in the mail informing you of your discount, if applicable.

I received a letter stating I qualified for a sliding fee discount. How long is this effective?
Your sliding fee scale approval expires each year on September 30th. You will need to reapply each year, around August, at which time we will reassess your eligibility for the program.

Since I qualified for a sliding fee discount last year, do I still need to go through the application process again?
Yes, enrollment expires every year on September 30th and a new application is required at that time.

Should you need help completing your application, please contact us at:

Mountain Community Health
61 Pine Street
Bristol, VT 05443
Phone: 802-453-3911
Fax: 802-453-6105
www.mchvt.org

Mountain Community Health

This is the current table for 2023.

MCH Medical						
Household FPL	**A**	**B**	**C**	**D**	**E**	**F**
Size	**<100%**	101%-**125%**	126%-**150%**	151%-**175%**	176%-**200%**	**>200%**
1	$13,590	$16,988	$20,385	$23,783	$27,180	$27,181
2	$18,310	$22,888	$27,465	$32,043	$36,620	$36,621
3	$23,030	$28,788	$34,545	$40,303	$46,060	$46,061
4	$27,750	$34,688	$41,625	$48,563	$55,500	$55,501
5	$32,470	$40,588	$48,705	$56,823	$64,940	$64,941
6	$37,190	$46,488	$55,785	$65,083	$74,380	$74,381
7	$41,910	$52,388	$62,865	$73,343	$83,820	$83,821
8	$46,630	$58,288	$69,945	$81,603	$93,260	$93,261
Add per additional person	$4,720	$5,900	$7,080	$8,260	$9,440	$9,440
Discount	**100%**	**90%**	**80%**	**70%**	**60%**	**0%**
Patient Responsibility	**$10 per visit**	**10%**	**20%**	**30%**	**40%**	**100%**

MCH Dental					
Household FPL	**A**	**B**	**C**	**D**	**E**
Size	**<100%**	101%-**133%**	134%-**167%**	168%-**200%**	**>200%**
1	$13,590	$18,075	$22,695	$27,180	$27,181
2	$18,310	$24,352	$30,578	$36,620	$36,621
3	$23,030	$30,630	$38,460	$46,060	$46,061
4	$27,750	$36,908	$46,343	$55,500	$55,501
5	$32,470	$43,185	$54,225	$64,940	$64,941
6	$37,190	$49,463	$62,107	$74,380	$74,381
7	$41,910	$55,740	$69,990	$83,820	$83,821
8	$46,630	$62,018	$77,872	$93,260	$93,261
Add per additional person	$4,720	$6,278	$7,882	$9,440	$9,440
Basic Dental Discount	**100%**	**55%**	**40%**	**20%**	**0%**
Basic Patient Responsibility	**$35 per visit**	**45%**	**60%**	**80%**	**100%**
Advanced Dental Discount	**100%**	**30%**	**20%**	**15%**	**0%**
Advanced Patient Responsibility	**$50 per visit**	**70%**	**80%**	**85%**	**100%**

Mountain Community Health

61 Pine Street
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Patient Registration Consent Form

1. CONSENT TO TREAT

I (or my legal guardian or parents) authorize Mountain Community Health (MCH), the providers, and healthcare team members to perform therapeutic medical or dental care reasonably by today's standards. I understand that I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my provider.

2. AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

I, the patient (or the policyholder if the patient is not the policyholder), authorize and direct that all medical or dental benefits payable to or for the benefit of the Patient under the terms of any applicable insurance policy be paid directly to the providers affiliated with MCH. Patients agree to sign any additional assignment of benefits form requested by MCH or any insurance company from time to time. Patients understand that they are liable to providers at MCH for all related charges, whether or not covered by insurance.

3. ASSIGNMENT OF MEDICARE BENEFITS

I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

4. AGREEMENT TO PAY CHARGES

I, the patient/guarantor (where applicable), agree to pay my share of the costs for the services to be rendered by or through MCH providers in accordance with regular rates and terms. In the event of non-payment, the patient and guarantor (where applicable) understand that such non-payment will be reported to credit reporting agencies and agree to pay all reasonable costs of collection, including attorney fees. I understand that I may get bills from other outside third parties, such as Quest Diagnostic, UVMHN, Dominion, Indivior, etc. for services provided on my behalf, like lab specimens, diagnostics, or medications.

5. CONSENT TO RETRIEVE EXTERNAL PRESCRIPTION HISTORY

I authorize MCH to obtain and use my external prescription history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

6. RELEASE OF INFORMATION

I acknowledge and understand that MCH may share my health information and records with other providers that are treating me for medical or dental services provided by MCH providers to any of the following: (a) my insurance company or any other third party insurance payer (b) my continuing care facility, (c) any organization involved in planning my discharge from MCH, (d) any organization performing utilization review pursuant to state or federal law, and (e) any health care agency authorized by law. I, the patient, acknowledge that the medical or dental records covered above may include information concerning mental illness conditions, substance or alcohol abuse, and worker's compensation.

The confidentiality of substance-use disorder records received by MCH from certain Substance Use Disorder Treatment Programs is protected under federal regulations (42 CFR Part 2), which prohibit any person or entity, including MCH, from making further disclosure of this information unless such disclosure is expressly permitted by my separate written consent or as otherwise permitted by 42 CFR Part 2.

7. CONSENT TO WIRELESS CALLS, TEXTS, AND E-MAILS

I consent to receive calls, texts, and emails from MCH, its agents, or its representatives at the numbers and email addresses I provided during registration for the following purposes: appointment reminders, general health reminders, billing, and patient experience surveys. Messages may be generated and sent using an automated notification. I understand that I am not required to provide this consent in order to receive healthcare services. I understand that message data rates may apply depending on my contract with my carrier. I understand that I have the right to revoke this consent orally or in writing.

_____ _____

Signature of Patient (if older than 12 years old) **Date**

_____ _____

Signature of Parent or Authorized Representative **Date**

Relationship to Patient: _____