Hopewell Health Centers, Inc.

Help us get to know you! By reviewing the information below, our team can work together to meet your individual needs.

Patient General Information

Last _____ First _____ MI _____ Date of Birth _____ Social Security # _____

Address (Street & PO Box) _____ Home Phone _____ Cell Phone _____ Msg/Work Ph _____ Email _____

City _____ State ____ Zip Code _____ County _____ Employer _____

Occupation _____ By whom were you referred? _____

Emergency Contact: Relationship _____ Name _____ Phone _____

Preferred Pharmacy: _____ Preferred Contact Method: ○ Call ○ Text ○ Email

Clear

Patient Demographic Information

Birth Sex	Learning Preference	Language	Veteran
☐ Male	☐ Oral	☐ English	☐ YES
☐ Female	☐ Visual	☐ Other	☐ NO
☐ Unknown	☐ Written		

NOTE: To provide clarification or further information for this section or any section of this document, go to Page 4: Miscellaneous Comments & Information.

Marital Status	Gender Identity	Sexual Orientation
☐ Single	☐ Male (M)	☐ Lesbian/Gay/Homosexual
☐ Married	☐ Female (F)	☐ Straight
☐ Divorced	☐ Transgender (M to F)	☐ Bisexual
☐ Partner	☐ Transgender (F to M)	☐ Don't know
☐ Unknown	☐ Neither exclusively M or F	☐ Choose not to disclose
☐ Widowed	☐ Choose not to disclose	☐ Something else:
☐ Legally separated	☐ Something else:	

Race			Ethnicity
☐ White	☐ Samoan	☐ Korean	☐ Mexican,Mexican American, Chicano/a
☐ Black/African American	☐ Asian Indian	☐ Vietnamese	☐ Puerto Rican
☐ American Indian/Alaska Native	☐ Chinese	☐ Other Asian	☐ Cuban
☐ Guamanian or Chamorro	☐ Filipino	☐ Declined	☐ Another Hispanic, Latino/a or Spanish origin
☐ Native Hawaiian	☐ Japanese		☐ Not Hispanic, Latino/a or Spanish origin
☐ Other Pacific Islander	☐ More than one race		☐ Declined
☐ Other race:			☐ Other:

Patient Social Services Involvement

What other agencies, offices, or health providers are you working with?

☐ Department of Job and Family Services ☐ Parole/Probation Officer = _____

☐ Children Services-County & caseworker: _____ Do you have a case plan? ☐ Yes ☐ No

☐ Legal Service/Lawyers/Courts: _____

☐ Medical Service Providers: _____

☐ Home Health: _____

☐ Other Service Providers: _____

Hopewell Health Centers, Inc. Patient Information - Continued

Patient Medications

CURRENT Medications (Prescription, Over the Counter, Vitamins, Herbal)

Please fill this out to the best of your ability. All information below must be included.

☐ No medications ☐ Additional medications on page 4: Miscellaneous Comments & Information

Medications	Dose & Frequency	Prescribed by	How long taken?	Reason for use	Helpful?	Take regularly?
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N

Adult Patient only (if the patient is a child, go directly to the next section)

Do you currently have a legal guardian? ☐ NO ☐ YES Do you currently have a payee? ☐ NO ☐ YES

If yes: Guardian Name_____ Address:_____ Phone:_____

Payee Name_____ Address:_____ Phone: _____

Please provide legal documentation of guardianship.

Do you have an Advance Directive? ☐ NO ☐ YES ☐ Don't know what this is

If yes, please give your service provider a copy of your Directive. If you would like more information about Advance Directives, please ask service provider.

Child Patient only (if the patient is an adult go directly to the next section)

Name of Person completing form: _____

Relationship: ☐ Parent ☐ Foster parent ☐ Children Services worker ☐ Other: _____

Custody: ☐ Share custody ☐ Custodial parent ☐ Single parent (never married/widowed) with custody

☐ Non parental: Relationship: _____ Phone (if different)_____ How long have you had custody?_____

☐ Other: _____ Please provide legal documentation of custody.

Patient Financial & Billing Information

Responsible Party ☐ Self ☐ Other Relationship _____

_____ _____ _____ ____ _____

Name Address City State Zip

Insurance Information

Primary insurance _____

Address _____

Insurance ID _____

Policy Holder Name _____

_____ _____

Social Security # Date of Birth

Employer _____

Secondary insurance _____

Address _____

Insurance ID _____

Policy Holder Name _____

_____ _____

Social Security # Date of Birth

Employer _____

Income worksheet

Use the spaces below to calculate annual income from hourly wages or weekly, bi-weekly, or monthly income - or to add multiple sources of income together for one household member. Use the results to fill in the income information requested below.

Convert hrly , weekly, biweekly, or monthly amounts to annual income:

			Annual income
Hourly wage	Hours worked per week	Weeks worked per yr	$0
Weekly income		Weeks worked per yr	$0
Every two week income		Weeks worked per yr	$0
Monthly income		Months per yr	$0

Add up multiple annual income amounts for a household member. Use annual amounts.

Employment : Social Security: Child support:

Other 1 : Other 2 : Other 3:

Total: $0

To reuse the worksheet, clear all calculations

Provide annual income information for your household, below

Total number in household: _____ number of persons related by birth, marriage, adoption, or guardianship, living in the same house

List ALL Household Members and Annual Income (if applicable). Annual Income should include all sources - wages, child support, social security, etc. For help calculating annual income amounts, see income worksheet on above.

Name	DOB	Relationship	Annual Income
			$ 0 /yr
			$ 0 /yr
			$ 0 /yr
			$ 0 /yr
			$ 0 /yr
			$ 0 /yr
			$ 0 /yr
			$ 0 /yr

Total household income: $ 0 /yr

If there are more than 8 members in the household, provide further information on page 4: Miscellaneous Comments & Information

☐ I am refusing the Sliding fee discount ☐ I am applying for the Sliding Fee discount

Proof of Income must be provided to receive a Sliding Fee discount. Provide proof for all household members: pay stubs, child support, unemployment, disability, social security (must be award/benefit letter).

For Office Personnel Use Only

Sliding Fee discount_____ Sliding Fee Expiration_____

Miscellaneous comments and information

Add any clarifications or additional information in the space below.

When filling out this document on-screen, you must complete this Acceptance section. NOTE: By selecting "I Accept," you are confirming your intent to sign this document electronically.

ACCEPTANCE OF ELECTRONIC SIGNATURE:

☐ I ACCEPT. I am signing this document by typing my name in the Signature field(s) below.

☐ I DO NOT ACCEPT. I will print out and sign a paper copy and deliver or mail it to my healthcare provider.

SIGNATURE:

I certify that, as of this date, all the information I have provided in this document is correct to the best of my knowledge. I authorize payment of all insurance policy benefits to be paid directly to Hopewell Health Centers, Inc. This will include information necessary to determine eligibility for public funds for behavioral health services, to enroll me/my child in GOSH, and to obtain payment for treatment rendered which is submitted to appropriate ADAMHS Board or the county of my residence. I also understand that failure to notify Hopewell Health Centers, Inc. of any additions or corrections will terminate my eligibility for the sliding fee, should I qualify. Any false statement will jeopardize the discount and result in the requirement of full payment of my account.

Patient Signature _____ Date _____

Parent or Legal Guardian _____ Date _____

Clear Entire Form

MACSIS RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjucating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-country).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-country).

A client or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client is an adult? ☐ Yes ☐ No **If yes, complete the following information.**	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	Date

Minor

Client is a minor? ☐ Yes ☐ No	**If yes, indicate if child is in legal custody of the following (this is not the foster parent).** ☐ Parent ☐ CSB ☐ DYS ☐ Court ☐ Other (specify): _____
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone No. of Legal Custodian
County of Legal Custodian	
If Parent, Address of Parent (if different from client's address on enrollment form)	
Signature of Legal Custodian	Date

*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.