CIFC Health

Patient Information

Last Name:	First Name:	M.I.	DOB (mm/dd/yyyy):

Street Address:	Apt/Floor:	City:	State:	Zip Code:

Primary Pharmacy (including address):	Primary Care Provider (PCP):

Insurance

Do you have Health Insurance? ☐ **YES** ☐ **NO**

If NO, would you like to see if you qualify for? ☐ Health Insurance – Access Health CT ☐ Financial Assistance (sliding-fee scale)

PRIMARY

Company Name:	ID #:	Group #:

Last Name:	First Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:

SECONDARY

Company Name:	ID #:	Group #:

Last Name:	First Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:

Person Responsible for Payment

Person Responsible for Payment: ☐ **Patient** **(if checked, skip to next section)** ☐ **Parent/Guardian** ☐ **Spouse** ☐ **Other:** _____

Last Name:	First Name:	M.I.	Date of Birth (mm/dd/yyyy):	Phone:

Street Address:	Apt/Floor:	City:	State:	Zip Code:

Income — CIFC Health receives Federal Grants which require us to ask for this information.

# of People in Household: _____	Household Income: $_____	☐ Annually ☐ Monthly: How many months/year? _____ ☐ Weekly: How many weeks/year? _____

Required Information

Are you Homeless?
☐ **YES** *(Select below)* ☐ **NO** *(Skip below)*
- ☐ Doubling-up *(living with another family)*
- ☐ Street
- ☐ Homeless Shelter *(temporary/overnight stay)*
- ☐ Transitional *(longer temporary housing)*
- ☐ Other: _____

Marital Status:
- ☐ Single
- ☐ Separated
- ☐ Divorced
- ☐ Married
- ☐ Together
- ☐ Widowed

Employment Status:
- ☐ Retired
- ☐ Employed – Full-time
- ☐ Employed – Part-time
- ☐ Self-Employed
- ☐ Unemployed
- ☐ Student – Full-time
- ☐ Student – Part-time
- ☐ N/A (Child)

Ethnicity:
Hispanic/Latino
- ☐ Yes

Which country:

_____
- ☐ Not Hispanic/Latino
- ☐ Decline to answer

Race:
- ☐ White
- ☐ Black/African American
- ☐ Asian:

Which country:

_____
- ☐ Native American/Alaskan
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Decline to answer

Sex Assigned at Birth:
- ☐ Male
- ☐ Female

Are you a Veteran?
- ☐ YES
- ☐ NO

Migrant Worker:
☐ YES ☐ NO

Seasonal Worker:
☐ YES ☐ NO

Language Preference:
- ☐ English
- ☐ Spanish
- ☐ Portuguese
- ☐ Other: _____

Need Translator?
- ☐ YES
- ☐ NO

Signature of Patient/Guardian:	Date:

CIFC Health Office Use Only:

1. Photo ID was:	2. Insurance Card was:	3. Documents Given:	4. Financial Assistance Eligibility:	5. Data Consent:
☐ Copied/Scanned	☐ Copied/Scanned	☐ Welcome Letter/PCMH Packet ☐ ROI Update (BH)	☐ Addressed	☐ Response documented in eCW

Staff Initials: _____