COMMUNITY HEALTH PARTNERS

Patient Information: Annual Update

Please complete all information on both sides of this form. Include only patient's information below.

If you are filling out this form for a minor or someone else (not yourself), write only that person's information

Patient's Legal Name:_____ **Preferred Name:** _____

Other names you have used: _____

Legal guardian (if under age 18):_____

Social Security Number:_____ **Date of Birth**:_____ **Sex Assigned at Birth**: □ Male □ Female
Month/Day/Year

Mailing Address _____
Address or P.O. Box **City** **State** **Zip**

Phone _____ **Email** _____ □ Patient □ Parent/Guardian

Community Health Partners receives some federal funding. Therefore, we are required to ask the following questions once each calendar year. All information will be kept strictly confidential.

Marital Status:_____ **Preferred Language:**_____

Primary Care Provider? _____ **Visually impaired?** □ Yes □ No **Hard of Hearing?** □ Yes □ No

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unavailable/Unknown

Race (check all that apply): □ African American □ Asian □ Pacific Islander □ White □ Native Hawaiian
□ Unknown □ American Indian/Alaska Native □ Declined

Employment Status: □ Full time □ Part time □ Disabled □ Retired □ Full-Time Student
□ Part time Student □ Unemployed

If Employed, Employer: _____ **Military Veteran?** □ Yes □ No □ Active Military

Are you a CHP/One Health employee or a dependent of a CHP/One Health employee? □ Yes □ No

In the past two years, have you: 1. Moved to a new location to do farm or ranch work? □ Yes □ No
2. Done farm or ranch work on a seasonal basis? □ Yes □ No

In the past year have you lived in a shelter, halfway house, in your vehicle or on the street, or temporarily lived with family or friends? □ Yes □ No

Sexual Orientation: □ Lesbian, gay or homosexual □ Straight or heterosexual □ Bisexual □ Other
□ Don't Know □ Choose not to disclose □ Unknown

Gender Identity: □ Male □ Female □ Transgender Male: Female-to-Male
□ Transgender Female: Male to Female □ Other □ Choose not to disclose □ Non-Binary

Emergency Contact: _____ **Phone Number:** _____

Emergency Contact's Relationship to you: _____

□ I am on CHP sliding scale or I would like to apply for the CHP sliding scale discount today.

Second Page

Who is responsible for today's charges (Guarantor)? □ Self (Adult 18 or older) □ Parent/Legal Guardian
□ Other (employer, work comp, accident related)

Guarantor Name: _____ Relationship to patient: _____

Address: _____

Social Security #_____Phone: _____ Date of Birth _____
Month/Day/Year

Employer _____

Do you have insurance that can help pay for today's visit? (Please check all that apply)

□ Private Insurance □ Medicare □ Medicaid □ Healthy Montana Kids (formerly CHIP)
□ Workers' Comp □ Auto Accident Coverage

Policy Holder Name: _____ Policy Holder's Birth Date: _____
Month/Day/Year

Insurance Company:_____ Insurance ID Number: _____

Policy Holder Address: _____

Please provide your insurance card with this form. If you don't have your insurance card with you today, please bring it in as soon as possible or you will receive a bill for the full charge.

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What is your annual household income?

Instructions: *Find your family size then pick a **box in that row** that best describes your household income.*

Family Size	Income Range You may qualify for Medicaid coverage – ask our team!	Income Range	Income Range	Income Range
1	❑ $0 to $15,060	❑ $15,061 to $22,590	❑ $22,591 to $30,120	❑ $30,121 and over
2	❑ $0 to $20,440	❑ $20,441 to $30,660	❑ $30,661 to $40,880	❑ $40,881 and over
3	❑ $0 to $25,820	❑ $25,821 to $38,730	❑ $38,731 to $51,640	❑ $51,641 and over
4	❑ $0 to $31,200	❑ $31,201 to $46,800	❑ $46,801 to $62,400	❑ $62,401 and over
5	❑ $0 to $36,580	❑ $36,581 to $54,870	❑ $54,871 to $73,160	❑ $73,161 and over
6	❑ $0 to $41,960	❑ $41,961 to $62,940	❑ $62,941 to $83,920	❑ $83,921 and over
7	❑ $0 to $47,340	❑ $47,341 to $71,010	❑ $71,011 to $94,680	❑ $94,681 and over
8	❑ $0 to $52,720	❑ $52,721 to $79,080	❑ $79,081 to $105,440	❑ $105,441 and over
9+	How many people are in your household? _____ What is the combined annual income for all members of your household $_____?			

❑ I choose **not** to provide my family income information.

Signature _____ Today's Date _____

For Office Use Only
Slide Status: Active ☐ Date Expired _____ Patient Declined Slide ☐ Will Return Ppwk by: _____ Entered by_____ Date____