Family Shared Cost Program

Thank you for your interest in the CCHC Family Shared Cost Program. The FSCP is designed to provide quality, compassionate health care regardless of an individual's financial or employment condition. Please take a moment to read over the guidelines for the Family Shared Cost Program. It is important to us that you understand how the program works. Should you have any questions or need assistance in completing the application, please do not hesitate to ask a member of our staff.

How did you hear about us? ____
____

You will be required to turn in the information listed on the following page with your application as soon as possible in order for your screening process to begin. If you are not able to provide all the necessary information, please speak with the Eligibility Screener. If you do not meet eligibility criteria for the FSCP program, you will be responsible for all visit charges. In such cases, we will work with you to provide a reasonable payment arrangement.

Patients enrolled FSCP will be rescreened once a year. At the time of your rescreening, you will be required to resubmit the screening documents and a new application. If you have not already done so, you will need to apply for Medicaid. **This is required for all patients on FSCP.**

In the event that your child is sick and needs to be seen in the Emergency Room, you will be responsible to pay for all services rendered there. Please speak with a representative at the Emergency Room and ask to apply for their uninsured program.

Lastly, if you have any changes in address or employment status, you will need to notify the office within two (2) weeks. Intentionally falsifying information in the application is grounds for discharge from the program.

Participation in the Caroline Christian Health Center Family Shared Cost Program implies that you understand and agree to the above.

Patient printed name: ____ Date: ___________________

Patient or Responsible party's signature:
____

Family Shared Cost Program Enrollment Checklist

Please have the following information available with your application. This will allow the office to quickly process your FSCP application.

- ☐ Social Security Card (for child) or copy of birth certificate
- ☐ Income verification:

  Previous year W-2 form or federal tax return. If unavailable, then past 3 month pay stub/ cancelled check.

- ☐ Documentation of the following (if parent(s) receive these benefits):

Disability	Pension
Workman's Compensation	Survivor Benefits
Social Security	Unemployment
Child Support	Alimony

- ☐ Letter of denial of Medicaid/ Medicare eligibility

Family Shared Cost Program Application

Please fill out all applicable areas completely. This will allow the office to quickly process your application quickly.

Date: ____/____/____ Patient Status: New Rescreen

Name: (Last) ___________________________ (First) ______________________ (MI) ______

Date of Birth: ____/____/____ Patient SSN: ______-________-__________

Race: Asian Black Hispanic Native American Caucasian Other ____________Sex: Male Female

Guarantor Name: ____

Home address: ____

Street/P.O. Box: ____

City: ____________________________________ State: ___________ Zip: __________

Home Phone: (_____)______-______ Cell phone: (____) ____-______ Alt: (____) ____-_____

Mailing address, if different: _______________________________________

Street/P.O. Box: ____

City: ____________________________________State: ______ Zip: _____________

Emergency contact (not living with you):

Name: ____

Address: ____

Phone: (_____)______-_______

Relationship to patient: ____

Household size (include patient): This section is very important to complete. Please let us know how many individuals are being supported by the above stated income.

Name: _____________________ DOB: ____/____/____ Relationship to guarantor:___________

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Answering the following questions will not keep your child from receiving assistance or care at Caroline Christian Health Center and this information will not be passed on to third parties unless court ordered.

Is the child a US citizen? ____ Yes ____ No If no, does the child have a Resident Alien Card? Y/N

Medicaid/Medicare Eligibility

Does the child/ patient have state funded insurance through Medicaid or FAMIS? Y N Have you applied for Medicaid or FAMIS programs? Y N

When? ________________________

You must apply for state funded insurance if you are eligible. Please see one of our staff if you have questions about the application process. We have applications available both in English and Spanish

If your application was denied, please give a short explanation as to the reason why.

____

____

Where did you receive health care services prior to coming here?

____

Is your child currently enrolled with the WIC (Women, Infants, and Children) Program? Y N

Are you having any problems with getting food, shelter, and/or clothing?

____

Parent/Guardian Employment:

Is anyone in the household employed? Y N

Father Employer:____________________ $/ month_______ Started ________ Ended _________

Mother Employer:____________________ $/ month_______ Started ________ Ended _________

Other Employer:_____________________ $/ month_______ Started ________ Ended _________

If the parent/guardian is self-employed: What type of work do they do?

____

If yes, what is their monthly/annual salary? _____________________________

If parent/guardian is unemployed, please mark all applicable reasons: Student______

Housewife_____ Retired_____ Laid off_____ Illness/injury _____Can't find work _______

Additional sources of financial income for family:

Child Support: $_____________/wk or $____________/mo or $ ______________/yr

Alimony: $_____________/wk or $____________/mo or $ ______________/yr

Pension: $_____________/wk or $____________/mo or $ ______________/yr

Social Security: $_____________/wk or $____________/mo or $ ______________/yr

Unemployment: $_____________/wk or $____________/mo or $ ______________/yr

Date Started: ______/______/_______ Date Ended: ______/______/_______

Other: _________________________: $_____________/wk or $____________/mo or $ ______________/yr

If you have NO income, how are you currently meeting your living needs?

____

____

Please be aware that the Family Shared Cost Program DOES NOT COVER Emergency Room visits, specialist visits, lab, xray or pharmacy costs. Although some discounts MAY apply to these extended services, we cannot guarantee that they will apply in all situations.

I acknowledge by signing this form, that this information is up to date and current to the best of my knowledge.

____ ______/______/_______

Patient or Parent/Guardian signature Date

____

Eligibility Screener signature