Long Island
Select Healthcare

Dear Patient,

According to Long Island Select Healthcare policy, we need to request certain documentation from you. These documents are related to our federal funding and help us stay open to provide services to you. If you are applying for our sliding fee scale, we will ask you for acceptable proof of income. Acceptable proof of income includes:

- Your most recent income tax return
- Your most recent W-2 form
- 2 Paystubs from your most recent employer
- A determination letter from social security detailing amounts awarded
- A written statement of income from your employer
- A bank statement showing direct deposit amounts
- If you are not employed or cannot provide proof of income, please fill out a Self-attestation form

Once you provide us with proof of income and we verify your eligibility for our sliding fee scale you will be eligible under the assigned schedule for a period of one year. If at any time during the year your income levels change, please bring in additional proof of income so we may re-assess your eligibility for our sliding fee scale.

Please note that without acceptable proof of income we will be unable to assess your eligibility for our sliding fee scale and you may be responsible for any charges not covered by your insurance company.

Long Island Select Healthcare is committed to providing patients with excellent healthcare services at reasonable costs. If, at any time, you have any questions or concerns please feel free to contact us.

Thank you,

Long Island Select Healthcare

Long Island Select Healthcare

# Eligibility Determination for Sliding Fee Discounts

It is the policy of Long Island Select Healthcare, Inc. (LISH, Inc.) to provide essential services to all patients regardless of the patient's ability to pay. Discounts are set by the LISH consumer Board of Directors and are offered based on the information you provide regarding your family size and income. If you are eligible for a sliding fee discount, it will apply to all services received at LISH, but not for those services provided outside the Health Center.

**Please complete the following information, even if you have insurance.**

**Household Income Before Taxes**

| Household Member | Number | Monthly Income | Yearly Income |
|---|---|---|---|
| Your name: | | | |
| Spouse name: | | | |
| Dependent children | | | |
| Other dependents | | | |
| Total | | | |

☐ I decline to provide information on my income and family size and agree to pay the full LISH fee.

☐ I agree to provide proof of income at my next visit.

**Acceptable proof of income is required for the sliding fee discount program.**
**If your financial situation changes, please keep LISH informed.**

I certify that all information shown above is true, accurate, and correct. I understand that if LISH determines that I misrepresented or falsified information, I will no longer receive discounts and may be asked to pay back discounts provided.

Print name:_____ Signature: _____

Witness:_____ Date: _____

*Staff to complete remaining*

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Eligible for sliding fee discount? Yes _____ No _____ Patient refused _____

If yes, acceptable proof of income provided? Yes _____ No _____ Patient refused _____

If insured, health insurance card provided? Yes _____ No _____ Not applicable _____

Patient reports no income. Yes _____

Patient is unable to obtain proof from an employer. (Includes paid in cash/off-the-books earnings.) Yes _____

If yes to either question, use the Self-Attestation form.

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# LISH, Inc. Patient Intake Form

## Patient's Demographics:

**Primary Facility:** _____ **Primary Doctor:** _____
**Last Name:** _____ **First Name:** _____
**Preferred Name:** _____ **Date of Birth:** ___/___/_____
**Sex:** Male / Female Transgender ☐ Preferred Pronoun: _____
**SSN#:** ____-____-_____ **Primary Language:** _____

**Race:** ***(check all that apply)***
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian
☐ Black or African American
☐ White
☐ Other Race
☐ Other Pacific Islander
☐ Unreported/Refused to Report

**Ethnicity:**
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unreported/Refused to Report

**Mailing Address:** _____
**Apt #:** _____**City:** _____ **State:** _____ **ZIP:** _____
**Physical Address** ***(if different from mailing):*** _____
**Apt #:** _____**City:** _____ **State:** _____ **ZIP:** _____
**Home Phone:** _____ **Cell Phone:** _____
**Work Phone:** _____ **Email Address:** _____

**Relationship Status: (*check one*)**
☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Separated
☐ Partner

**Student Status: (*check one*)**
☐ Full Time
☐ Part Time
☐ Not a Student

**Employment Status: (*check one*)**
☐ Full Time
☐ Part Time
☐ Retired
☐ Active Duty
☐ Self Employed
☐ Unemployed

**Employer Name:** _____
**School Name:** _____

## Parent/Guardian Information:

**Parent / Guardian Name:** _____ **DOB:** ___/___/_____
**Address:** _____ **Phone:** _____
**Parent / Guardian Name:** _____ **DOB:** ___/___/_____
**Address:** _____ **Phone:** _____

## Emergency Contact:

**Name:** _____ **Relationship to Patient:** _____
**Address:** _____ **Phone:** _____

## Pharmacy Information:

**Name:** _____ **Address:** _____
**City:** _____ **ZIP:** _____ **Phone:** _____

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## Insurance Information:

**Primary Plan Name:** _____ **Policy Number:** _____
**Primary Care Provider on Insurance Card:** _____

**Secondary Plan Name:** _____ **Policy Number:** _____
**Primary Care Provider on Insurance Card:** _____

**Responsible Party Information:**
**Name:** _____ **Address:** _____
**City:** _____ **ZIP:** _____ **Phone:** _____
**Relationship to Patient:** _____

## Please indicate how you would like us to contact you:

Would you like access to our patient portal? [ ] Yes [ ] No
Preferred telephone number: [ ] Home [ ] Cell [ ] Work
Is it ok for us to leave a message? [ ] Home [ ] Cell [ ] Work
Best time of day to reach you: [ ] Morning [ ] Afternoon [ ] Evening
Preferred Language: [ ] English [ ] Spanish [ ] Other: _____

## The following questions help LISH, Inc. receive funding so we can make sure that your health care is affordable.

## Please check all that apply:

[ ] **Migrant Worker**
Are you currently working in agriculture or farm work? [ ] Yes [ ] No
Was your income mostly the result of farm work last year? [ ] Yes [ ] No
Is your family's income mostly from farm work? [ ] Yes [ ] No
Do you move around in search of farm work? [ ] Yes [ ] No

[ ] **Seasonal Worker**
Will you return to your home state/country after the growing season? [ ] Yes [ ] No

[ ] **Homeless/Living in a Shelter**
Do you live in a shelter or weekly/monthly rental? [ ] Yes [ ] No
Within the last year? [ ] Yes [ ] No
Do you share a single family housing with one or more families? [ ] Yes [ ] No
Or with more than 3 unrelated people? [ ] Yes [ ] No
Within the last year? [ ] Yes [ ] No
Are you currently living with family or friends while looking for housing? [ ] Yes [ ] No

[ ] **Living in Public Housing**
Do you currently live in public housing? [ ] Yes [ ] No
Within the last year? [ ] Yes [ ] No
Do you currently live in senior housing? [ ] Yes [ ] No
Within the last year? [ ] Yes [ ] No
Do you receive Section 8 housing benefits? [ ] Yes [ ] No
Within the last year? [ ] Yes [ ] No

## Are you: *(Please check all that apply)*

[ ] **Veteran**
[ ] **LISH, Inc. Employee**
[ ] **LISH, Inc. Board Member**

## How did you hear about us? *(Please check one)*

[ ] **Referred by**
[ ] LISH, Inc. Employee [ ] LISH, Inc. Patient [ ] Community agent [ ] Advertisement
[ ] Newspaper [ ] Flyer/Poster [ ] Online [ ] LISH, Inc. Event

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# LONG ISLAND SELECT HEALTHCARE CONSENT FORM

**Consent to Treatment**. I authorize Long Island Select Healthcare, Inc. ("LISH, Inc."), and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of LISH, Inc.'s medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by HRH personnel.

**Release of Information**. I authorize LISH, Inc. to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable LISH, Inc. to obtain payment for the services it provides to me; and (3) to permit LISH, Inc. to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.

I am aware that this authorization to use and disclose information may include information regarding:

- HIV or AIDS
- Alcohol or drug abuse
- Mental illness or any mental health condition
- Sexually transmitted diseases
- Family planning, pregnancy and abortion
- Genetic tests or genetic diseases

I am aware that Long Island Select Healthcare may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

**Assignment of Benefits.** I assign to LISH, Inc. all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by LISH, Inc.

**Financial Obligations**. I agree, that, except as may be limited by law or LISH, Inc.'s agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at LISH, Inc. facilities in accordance with the rates and terms of HRH in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles.

**I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms.**

Patient or Responsible Party Signature: _____

Nature of Relationship to Patient (if patient not signing): _____

Date: _____

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**Acknowledgment of Receipt of Notice of Privacy Practices.** I acknowledge that I have been provided a copy of the Long Island Select Healthcare (LISH, Inc.) Notice of Privacy Practices, which describes how health information about me may be used and disclosed by LISH, Inc. and how I may obtain access to and control the use and disclosure of this information.

Signature of Patient Date

**Reports to NYS Immunization Information System**. I hereby authorize LISH, Inc. to report any immunizations that its medical staff administers to me to the New York State Immunization Information System.

Signature of Patient Date