Rosa Clark Medical Clinic Association

PATIENT ENROLLMENT APPLICATION

Name: _____ Date of Birth: _____

SS#: _____ Male _____ Female _____

Phone #: _____ Alternate #: _____ Email Address: _____

Address: _____ _____ _____ _____

Street City State Zip Code

Mailing address if different from above: _____

Race

Black/African American _____ White _____ Asian _____

Native Hawaiian/Pacific Islander _____ American Indian or Native Alaskan _____ More than one race _____

Ethnicity

Hispanic or Latino _____

Non-Hispanic or Latino _____

Preferred Language

English _____

Other _____

Please check if any of these apply to you

Homeless _____ Public Housing Resident _____ Food insecurity _____

Financial Strain _____ Housing Insecurity _____ Veteran _____

Lack of Transportation/Access toTransportation _____

Please list any physician's office, hospital, or medical facility that would have any of your medical records:

_____

Please list all prescription and over the counter medication you are taking:

_____

_____

Allergies

Medication _____

Other _____

Were you recently discharged from the hospital or emergency room?

_____ Yes _____ No If yes, when were you discharged? _____

Is your need for an appointment urgent: _____ Yes _____ No

If yes, please describe: _____

If you have insurance please list here: _____

Please provide Insurance Card to Enrollment Coordinator to Copy

How did you hear about Rosa Clark Medical Clinic? _____

To Receive the Sliding Fee Scale Discount, Please Complete the Following, Otherwise Go to Page 3

How many people live at the address above? _____

Please check the sources of income for ***all*** people living at this address:

List the amount of monthly Gross Income for each person in the home:

Self $ _____ Source of Income: _____

Other Household Income $ _____ Source of Income: _____

Other Household Income $ _____ Source of Income: _____

Total Monthly Gross Income $ _____

Rosa Clark Sliding Fee Scale 2024

	Plan 1	Plan 2	Plan 3	Plan 4
Persons in House-hold	**At or below 100% FPL or below**	**At 101% - 125% FPL**	**At 126% - 150% FPL**	**At 151% - 200% of FPL**
1	0 to $15,060	$15,061 to $18,826	$18,827 to $22,590	$22,591 to $30,120
2	0 to $20,440	$20,441 to $25,551	$25,552 to $30,660	$30,661 to $40,880
3	0 to $25,820	$25,821 to $32,276	$32,277 to $38,730	$38,731 to $51,640
4	0 to $31,200	$31,201 to $39,001	$39,002 to $46,800	$46,801 to $62,400
5	0 to $36,580	$36,581 to $45,726	$45,727 to $54,870	$54,871 to $73,160
6	0 to $41,960	$41,961 to $52,451	$52,452 to $62,940	$62,941 to $83,920
7	0 to $47,340	$47,341 to $59,176	$59,177 to $71,010	$71,011 to $94,680
8	0 to $52,720	$52,721 to $65,901	$65,902 to $79,080	$79,081 to $105,440
For families/households with more than 8 persons, add $5,380 for each additional person.				
There is no discount for household income over 200% of the Federal Poverty Guidelines				
Office Visit	$0.00	$2.00	$5.00	$10.00
Pharmacy Co-pay Per RX	$0.00 per RX	$1.00 per RX	$2.00 per RX	$3.00 per RX

Dental Clinic Sliding Fee Scale Provided Upon Request

We are required to verify your income in order to provide the sliding fee scale. We can use ***any*** of the following to verify your income:

Prior Year Income Tax Returns SNAP Eligibility Letter Last 4 Paystubs

Letter of Temporary Living Assistance Social Security Eligibility Letter

By signing below, I hereby attest:

1) That the above information is true and accurate and I hereby authorize treatment.
2) That I agree to notify the clinic if my address changes or if my insurance status changes.
3) That if I am receiving the sliding fee scale, I will notify the clinic if my income status changes.
4) I understand that Rosa Clark Clinic must be my Primary Care Medical Home in order to receive medications from the Rosa Clark pharmacy.
5) I give Rosa Clark Clinic permission to collect information about me on healthcare services received at facilities other than Rosa Clark including hospitalizations and emergency room visits.
6) I give Rosa Clark Clinic staff permission to enroll me in the SC Medicaid Healthy Connections Checkup Program if I do not have insurance.
7) I agree to re-enroll annually to continue receiving the sliding fee scale at the Clinic.
8) For after hours assistance, call the main line at 882-4664, ext. 6

Date	Patient Signature
Date	Enrollment Coordinator