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

White	______
Hispanic, Latino, or Spanish	______
Mexican, Mexican American, Chicano	______
BlackAfrican American	______
American Indian/Alaska Native	______
More than one race	______
Asian Indian	______
Chinese	______
Filipino	______
Japanese	______
Korean	______
Vietnamese	______
Other Asian	______
Native Hawaiian	______
Other Pacific Islander	______
Guamanian or Chamorro	______
Samoan	______

Ethnicity

Not Hispanic, Latino, or Spanish	______
Puerto Rican	______
Cuban	______
Another Hispanic, Latino, or Spanish	______
Hispanic, Latino, Spanish combined	______

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? _______

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 2025

	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	$15,650	$15,651	to	$19,564	$19,565	to	$23,475	$23,476	to	$31,300
2	0	to	$21,150	$21,151	to	$26,439	$26,440	to	$31,725	$31,726	to	$42,300
3	0	to	$26,650	$26,651	to	$33,314	$33,315	to	$39,975	$39,976	to	$53,300
4	0	to	$32,150	$32,151	to	$40,189	$40,190	to	$48,225	$48,226	to	$64,300
5	0	to	$37,650	$37,651	to	$47,064	$47,065	to	$56,475	$56,476	to	$75,300
6	0	to	$43,150	$43,151	to	$53,939	$53,940	to	$64,725	$64,726	to	$86,300
7	0	to	$48,650	$48,651	to	$60,814	$60,815	to	$72,975	$72,976	to	$97,300
8	0	to	$54,150	$54,151	to	$67,689	$67,690	to	$81,225	$81,226	to	$108,300
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

Revised 03/17/2025