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		**Ethnicity**	
White	_____	Not Hispanic, Latino, or Spanish	_____
Hispanic, Latino, or Spanish	_____	Puerto Rican	_____
Mexican, Mexican American, Chicano	_____	Cuban	_____
BlackAfrican American	_____	Another Hispanic, Latino, or Spanish	_____
American Indian/Alaska Native	_____	Hispanic, Latino, Spanish combined	_____
More than one race	_____		
Asian Indian	_____		
Chinese	_____	**Preferred Language**	
Filipino	_____		
Japanese	_____	English	_____
Korean	_____		
Vietnamese	_____	Other	_____
Other Asian	_____		
Native Hawaiian	_____		
Other Pacific Islander	_____		
Guamanian or Chamorro	_____		
Samoan	_____		

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 2026

	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 $15,960	$15,961 to $19,950	$19,951 to $23,940	$23,941 to $31,920
2	0 to $21,640	$21,641 to $27,050	$27,051 to $32,460	$32,461 to $43,280
3	0 to $27,320	$27,321 to $34,150	$34,151 to $40,980	$40,981 to $54,640
4	0 to $33,000	$33,001 to $41,250	$41,251 to $49,500	$49,501 to $66,000
5	0 to $38,680	$38,681 to $48,350	$48,351 to $58,020	$58,021 to $77,360
6	0 to $44,360	$44,361 to $55,450	$55,451 to $66,540	$66,541 to $88,720
7	0 to $50,040	$50,041 to $62,550	$62,551 to $75,060	$75,061 to $100,080
8	0 to $55,720	$55,721 to $69,651	$69,552 to $83,580	$83,581 to $111,440
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