BANYAN HEALTH SYSTEMS

Banyan Community Health Center

Registration Package
Sliding Fee Determination Form

Name: Last	First	Middle In.	/ / Date

Date of Birth: / / Social Security #: _____

Marital Status	Sex	Home Phone # :	Cell Phone # :
☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated	M ☐ F ☐		

Race

☐ American Indian/Alaskan Native ☐ Black / African American
☐ Asian ☐ Caucasian (white)
☐ Asian Pacific American ☐ More than one race

Country of Birth

Ethnicity:
☐ Hispanic
☐ Non-Hispanic

Street Address	City	State	Zip Code

Employment Status	Employer's Name	Work Phone No.	Email Address

Emergency Contact	Patient's relation to contact	Phone No.	Mother's Maiden Name

Do you have Medicaid? ☐ Yes ☐ No
Do you have Medicare? ☐ Yes ☐ No
Do you have Insurance? ☐ Yes ☐ No

Insurance Name _____
Member # _____
Group # _____

Do you have a JMH card? ☐ Yes ☐ No
JMH Card # _____

Spouse's Full Name: _____
Family Size: _____

Dependents Names and Date of Birth

1. _____
2. _____
3. _____
4. _____
5. _____

Annual Family Income
☐ Under $ 5,000
☐ $ 5,000 - $10,000
☐ $10,000 - $15,000
☐ $15,000 - $20,000
☐ $20,000 - $25,000
☐ $25,000 - $30,000
☐ $35,000 - $50,000
☐ Over $ 50,000

Under penalty of perjury, I declare that, to the best of my knowledge and belief, the information entered in this form is true, correct, complete, and made in good faith. If I intentionally provide false information, I understand that I will not be eligible for sliding fee discounts.

Signature:_____ **Date:**_____

Guardian Name:_____ **Witness:**_____