

Community Action of Laramie County, Inc
 Crossroads Healthcare Clinic for the Homeless

1700 Westland Road
 Cheyenne, WY 82001

Phone 307-635-9291
 Phone 307-632-8064

Personal Information

Last	First	MI	SSN#	Email	
Street Address	City	State	Zip	Home Phone	Mobile

Insurance Information

If you do not have insurance, please complete the application for sliding fee discount based on your income. Do you have insurance? yes no

Is your Insurance through an employer?	Yes	No	Employer
Insurance Carrier	Policy No.	Group No.	
Name of Insured: <input type="checkbox"/> Same as patient	Insured DOB: <input type="checkbox"/> Same as patient		

Demographics

Race: (Select all that apply)

- American Indian/Alaskan Native
- Black and/or African American
- White/Caucasian

Asian:

- Asian Indian
- Korean
- Chinese
- Vietnamese
- Filipino
- Other
- Japanese

Native Hawaiian/Pacific Islander:

- Native Hawaiian
- Guamanian/Chamorro
- Samoan
- Other Pacific Islander
- Decline to answer

Ethnicity:

- Non-Hispanic/Latino/a
- Dominican
- Cuban
- Mexican, Chicano/a
- Puerto Rican
- Other Hispanic/Latino/a
- Decline to answer

Marital Status:

- Divorced
- Married
- Single
- Widowed

Are you:

- Male
- Female

Are you a veteran?

- Yes
- No

Number in Household: _____

Housing Status:

- Stable Housing (rent or own)
- Transitional Housing (temporary)
- Homeless (without shelter)
- "On the streets"
- Staying at a shelter
- "Couch Surfing" / not paying rent

What is your employment status?

- Full Time
- Unemployed
- Part Time

Estimated Annual Household Income: \$ _____

Emergency Contact

Name:	Relationship:
Phone Number:	Alternate Number:

Disclaimer - By signing, I hereby certify that the above information, to the best of my knowledge, is correct and true.	Signature	Date
---	-----------	------

Consent to Treatment

I, (print name) _____ am voluntarily seeking medical care and treatment from Crossroads Healthcare Clinic for the Homeless and give permission to the staff of Crossroads Healthcare Clinic for the Homeless to examine, make diagnoses and provide treatment to me in accordance with the information, explanations and recommendations they provide me.

Consent to Billing

1. If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with Crossroads Healthcare Clinic for the Homeless Patient Financial Policy.
2. If my insurance is accepted, I will authorize payment of benefits to Crossroads Healthcare Clinic for the Homeless or will reimburse Crossroads Healthcare Clinic for the Homeless if I am paid directly by my insurance company.
3. I authorize that Crossroads Healthcare Clinic for the Homeless may furnish information concerning my illness and treatment to my insurance company in accordance with their privacy policy.
4. I am advised that any tests such as blood or other specimens, sent to an outside laboratory may result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory.
5. I understand that my insurance carrier may not cover all charges deemed medically necessary by Crossroads Healthcare Clinic for the Homeless.
6. I also understand that I am responsible for any part of the charges that are not covered by my insurance, and I will be billed for those services directly.

Patient Rights and Responsibilities

I have received a copy of the Crossroads Healthcare Clinic for the Homeless Patient Rights and Responsibilities.

Patient Signature: _____

Date: _____

Guardian/Parent: _____

Date: _____



Application for Income-Based Sliding Fee Scale

Name:		Date of Birth:	
Number of persons in your household. Include self, spouse, dependent children under 18 and other adults that may live there.		Adults:	Children:
Total Income: \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Hourly		
How often do you get paid:	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Hourly		
Proof of income is required as services are based on a discounted rate. Income is required to be updated annually, or every 12 months. Failure to provide income documentation after your 2nd visit will result in payment in full at each visit.			
Please check all sources of income:			
<input type="checkbox"/> Full time (32-40 hrs/wk) <input type="checkbox"/> Tax Forms <input type="checkbox"/> Alimony <input type="checkbox"/> Part time (31 hrs or less) <input type="checkbox"/> SNAP/Food Stamps <input type="checkbox"/> Unemployment benefits <input type="checkbox"/> Social Security <input type="checkbox"/> Pension <input type="checkbox"/> Child Support <input type="checkbox"/> Social Security Disability <input type="checkbox"/> Supplemental Social Security (SSI)			
If you are unable to provide income verification, please explain why:			
<input type="checkbox"/> I do not have documentation <input type="checkbox"/> I do not get paystubs or paychecks <input type="checkbox"/> I do not earn income <input type="checkbox"/> I get paid in cash			
Which financial documents are you providing to verify your total household income?			
<input type="checkbox"/> Pay Stubs <input type="checkbox"/> Bank Statements <input type="checkbox"/> Tax Forms <input type="checkbox"/> Letter of Unemployment <input type="checkbox"/> Other If other, please explain: _____			

I certify that I have provided all my income information and that all the above information is true and correct. I understand that this information is required to fulfill reporting processes and will be used to determine eligibility for Income Based services at Crossroads Healthcare Clinic for the Homeless if not insured. I also understand that if there has been an intentional misrepresentation of household income, I will be asked to repay any discounts that have been given and may lose future eligibility for discounts. False information may also lead to being discharged from Crossroads Healthcare Clinic for the Homeless. Please note, you may be required to meet with an Insurance Navigator to determine eligibility before receiving discounts for services.

I decline to provide income information and understand this may affect my ability to receive sliding scale discounts for any services I receive. _____(initials)

Patient Signature: _____

Date: _____



Acknowledgment of Receipt of HIPPA Notice of Privacy Practices

I, (print name) _____ acknowledge that I have received a copy of the Crossroads Healthcare Clinic for the Homeless HIPPA NOTICE OF PRIVACY PRACTICES.

Patient Signature: _____

Date: _____

I am the: Patient

Authorized Representative of Patient

Parent of Guardian **Power of Attorney** **Other** (specify): _____

Please note that you have right to refuse to sign this document

Written acknowledgment for the receipt of our Notice of Privacy Practices was not obtained because of the following reasons:

An emergency prevented us from obtaining the acknowledgment

A communication barrier prevented us from obtaining the acknowledgment

The patient or their representative were unwilling to sign

Other reason _____



Patient Responsibilities

The staff of Crossroads Healthcare Clinic for the Homeless warmly welcomes you and look forward to serving your healthcare needs. In order to best service you, there are several requirements and responsibilities that must be met on your part. Please read the information below carefully. If you have any questions, please ask a staff member for clarification.

- You have the responsibility to be courteous and considerate to all patients and the staff of Crossroads Healthcare Clinic for the Homeless.
- You have the responsibility and the right to participate in the decisions related to your care.
- You have the responsibility to be open and honest with us about the instructions you are given concerning your health. Let us know immediately if you do not understand them or feel you cannot follow them.
- You are responsible to bring information about past illnesses, hospitalizations, medications, and other matters related to your health and social history.
- You are responsible for being on time to your scheduled appointment or contact Crossroads Healthcare Clinic for the Homeless if you are unable to make that appointment.

Crossroads Healthcare Clinic for the Homeless was established to provide care for the unhoused population and a small number of housed persons in Laramie County. The services of Crossroads Healthcare Clinic for the Homeless are at a greatly reduced cost, and as a result, we need your help with our sliding fee scale, and housing/income verifications. Crossroads Healthcare Clinic for the Homeless is **NOT A FREE CLINIC**.

For those on the sliding scale fee, and who are below 100% of the Federal Poverty Guidelines, our fee of \$7.00, or your insurance co-pay amount, is asked for at each appointment. No emergent or urgent care situation will be denied if you are unable to afford this amount. We request proof of income from each patient. If you are working, we will need 30 days of paystubs or your tax returns from the previous year. If you have no income, we will accept letters from treatment centers, homeless shelters, safehouses and SNAP print out or a self-attestation form.

By signing below, you acknowledge that you have read and understand the above information and have been given a chance to ask questions.

Signature of Patient: _____

Date: _____



No Show Policy

Crossroads Healthcare Clinic for the Homeless wants to make sure that you have access to high-quality and affordable care when you need it. To ensure maximum access to our services (medical/behavioral), please review the below policy, initial and sign as noted:

(Initial) ___ Scheduling Appointments: Crossroads staff will make every effort to remind you of your upcoming appointments; however, ultimately you are responsible for remembering your appointment and arriving on time or calling ahead to inform staff of any possible delays.

(Initial) ___ Canceling Appointments: If for any reason you are unable to attend your appointment, please call us at least 24 hours in advance to let us know. If you reach the Crossroads voicemail box, please state your full legal name, birth date, and time/date of your appointment you are unable to attend.

(Initial) ___ Late Appointments: If you are expecting to be more than 10 minutes late for your appointment, please call ahead to alert our team. All patients arriving more than 10 minutes late with no call ahead may be subject to rescheduling appointments. Patients arriving more than 20 minutes late may be considered a missed appointment.

(Initial) ___ Missed appointments: Patients who fail to show up for appointments or give adequate notice (24 hours) may be removed from the schedule for future appointments. Repeated misses (3 within 6 months) of scheduled appointments can result in "Walk-in only" scheduling and can cause delays in seeing your provider.

(Initial) ___ No-Show Policy: Patients who miss more than 3 scheduled appointments in a 6-month period may be subjected to scheduling restraints that could result in delays of treatment.

BECAUSE OF A CRITICAL LACK OF ACCESS TO HEALTHCARE SERVICES IN OUR AREA MISSED APPOINTMENTS ARE TAKEN VERY SERIOUSLY. Please talk to any of our administrative staff if you have questions about our No-Show Policy. By signing below, you agree you understand the policy.

Patient or Parent/Guardian Signature: _____ Date: _____

FOR BEHAVIOR HEALTH VISITS ONLY: (Initials) ___ No-Show Policy: Behavioral Health patients who miss more than 3 scheduled appointments without adequate notice in a 6-month period will be required to speak to respective clinical leadership to discuss interest in continuing services before any additional appointments can be scheduled .

Patient or Parent/Guardian Signature: _____ Date: _____