HOMELESS DECLARATION

As a Federally Qualified Heath Center and a HRSA homeless services grantee, Health Partnership Clinic (HPC) allows a provision for waiving charges for patients experiencing homelessness. Homelessness is defined by the U.S. Department of Health and Human Services in section 330(h)(5)(A) as:

1. *An individual whose primary residence during the night is a supervised temporary public or private facility (i.e. shelters) and/or an individual who is a resident in transitional housing.*
2. *A homeless person is an individual without permanent housing who may live on the streets, stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle or any other unstable or non-permanent situation.*
3. *An individual may be recognized a homeless if that person has instability in their living arrangements and is forced to stay with a series of friends and/or extended family members.*
4. *Individuals who are to be released from a prison or hospital may be considered homeless if they do not have a stable housing situation to which they can return.*

Date of Declaration: _____

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Clinic Location: _____ Date of Appointment: _____

What is your HPC patient status? ☐ New ☐ Existing

Insurance Information

_____ I am currently not insured.

_____ I am currently not insured, but currently working or have worked in agriculture farm work in the last two years.

_____ I am currently insured. (Please complete patient registration)

Provide a brief explanation of your current living arrangements:

_____

_____

_____

Can you provide documentation supporting your homeless status? For example, letter from shelter or transitional housing authority, prison release document, etc.? ☐ Yes ☐ No

If yes, please submit copy of documentation

If no, can you provide contact information for someone who can attest to status? ☐ Yes ☐ No

If yes, Name: _____ Phone Number: _____

Medicaid Assistance

Have you applied for *Medicaid* in the last 6 months? ☐ Yes ☐ No

If yes, date of application and the state application completed:

_____

Was *Medicaid* application denied? ☐ Still pending ☐ Yes ☐ No ☐ N/A

Declaration

I understand that my signature confirms I am currently experiencing homelessness per the definition within this document and that Health Partnership Clinic may verify the information I have provided. I further understand the homeless status waiver is assigned temporarily and I will be required to update my status within 90 days of the date of this declaration.

Patient Signature Date

---------- **DO NOT WRITE BELOW THIS LINE-FOR HPC USE ONLY PSR COMPLETES** ----------

Does the patient meet the HHS definition of homelessness as stated in HPC Policy 12.21? ☐ Yes ☐ No

If no, why not? _____

Regarding Assistance:

If patient has a pending Medicaid application or could be eligible for Medicaid, has a follow-up appointment been made with HPC's Navigator? ☐ Yes ☐ No If yes, when? _____

Other comments or information to consider, if applicable?

_____
_____
_____

_____

Signature Date

Patient Account Update

☐ Patient status documented in eCW, structured data assigned, Homeless insurance carrier added in patient registration effective for 90 days, add as a Secondary Insurance if patient has health coverage.

☐ 90-day alert set on account: _____