



## School Based Portable Care

### 2023 – 2024 SCHOOL YEAR

### Student Enrollment Form

#### STUDENT INFORMATION

School Name		Grade Level	Teacher
Student Legal First Name		Middle Initial	Last Name
Date of Birth	SSN	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race			
<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <input type="checkbox"/> Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Native Hawaiian /Pacific Islander <input type="checkbox"/> Black/African American			
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> American Indian /Alaskan Native			
Ethnicity			
<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican/Mexican American/Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Another Hispanic/Latino/Spanish Origin			
Street Address			
City		State	Zip Code
Parent/Guardian Name		Date of Birth	SSN
Phone Number		Email	

#### INSURANCE INFORMATION

Check this box if an existing patient

<input type="checkbox"/> No Insurance <span style="background-color: yellow;"><i>Financial assistance is available to those who qualify</i></span>		
<input type="checkbox"/> KanCare/Medicaid           ID #	Aetna <input type="checkbox"/> United Healthcare <input type="checkbox"/> Sunflower <input type="checkbox"/>	
<input type="checkbox"/> Commercial/Private Insurance	<i>Insurance will be billed. Dependent upon your policy coverage, you may receive a bill. Financial assistance is available for those who qualify.</i>	
Insurance Company	Policy #	Group #
Subscriber Name		Date of Birth

*Patient: To be completed by HPC*

Patient Account #	Slide Level	Date of Service
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## FINANCIAL ASSISTANCE AVAILABLE FOR 2023 – 2024 SCHOOL YEAR

Due to the availability of grant funding to support school-based portable care for Sliding Fee Discount Program (SFDP) eligible uninsured and underinsured children, services will be provided at no cost to children whose families qualify for the SFDP. SFDP eligible insured patients will have claims filed and any patient responsibility will be covered by grant funding.

### FINANCIAL DISCLOSURE / SELF-ATTESTATION FOR FINANCIAL ASSISTANCE

As a Federally Qualified Health Center (FQHC) program, Health Partnership Clinic (HPC) is required to collect financial information to assess all patients receiving our services for available financial assistance through our Sliding Fee Discount Program (SFDP). Your family size and annual income will determine your eligibility for discounted services.

Based upon your disclosure of family size and income, a one-day presumptive eligibility may be granted one-time for students accessing school-based portable care in a school year. Existing HPC patients will default to current SFDP eligibility, if applicable.

**Step 1: Select One Check-Box option for your family's annual household income.**

**Step 2: Select your family's SFDP level by the # of family members, in the SFDP Level Box below.**

Family Size	Annual Household Income				
	1	\$0 - \$15,060	\$15,061 - \$20,030	\$20,031 - \$25,000	\$25,001 - \$30,120
2	\$0 - \$20,440	\$20,441 - \$27,185	\$27,186 - \$33,930	\$33,931 - \$40,880	\$40,881 o mayor
3	\$0 - \$25,820	\$25,821 - \$34,341	\$34,342 - \$42,861	\$42,862 - \$51,640	\$51,641 o mayor
4	\$0 - \$31,200	\$31,201 - \$41,496	\$41,497 - \$51,792	\$51,793 - \$62,400	\$62,401 o mayor
5	\$0 - \$36,580	\$36,581 - \$48,651	\$48,652 - \$60,723	\$60,724 - \$73,160	\$73,161 o mayor
6	\$0 - \$41,960	\$41,961 - \$55,807	\$55,808 - \$69,654	\$69,655 - \$83,920	\$83,921 o mayor
7	\$0 - \$47,340	\$47,341 - \$62,962	\$62,963 - \$78,584	\$78,585 - \$94,680	\$94,680 o mayor
8	\$0 - \$52,720	\$52,721 - \$70,118	\$70,119 - \$87,515	\$87,516 - \$105,440	\$105,441 o mayor
SFDP Level	A	B	C	D	E
	Eligible for Discounted Services				Not Eligible

*I certify the above is true and accurate and understand it will be used to determine my child's eligibility for discounted services. I understand falsified information may disqualify my family from eligibility for financial assistance.*

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### FINANCIAL AGREEMENT

As a parent or legal guardian of the patient named above and as applicable to my insurance and financial disclosure, I understand:	
1. Based upon my family size, my annual income must be at or below 200% of the Federal Poverty Guidelines (SFDP Level A – D), to qualify for discounted services.	
2. If my family qualifies for the SFDP, the cost of my child's services may be covered by a grant. If funding is not available and/or exhausted, I may be billed the appropriate slide level fee.	
3. If my child has no insurance, and my family does not qualify for SFDP, I will be billed in full for services provided to my child.	
4. I authorize the release of information necessary to process an insurance claim and payment directly to HPC.	
5. My insurance will be billed and dependent upon my policy coverage, I may receive a bill for services provided.	
6. My child's presumptive eligibility for the SFDP is for the date of this one-time school-based care service. If my child requires additional care at a HPC clinic location, I will be required to complete a Sliding Fee Discount Program Application and provide all required documentation to determine continued eligibility.	
Parent/Guardian Signature	Date