Health Partnership CLINIC

School Based Portable Care

2024 – 2025 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	☐ Male	☐ Female
Race ☐ White/Caucasian ☐ Korean ☐ Japanese ☐ Asian Other ☐ Chinese ☐ Native Hawaiian /Pacific Islander ☐ Black/African American ☐ Asian Indian ☐ Filipino ☐ Vietnamese ☐ Filipino ☐ Samoan ☐ Guamanian ☐ American Indian /Alaskan Native				
Ethnicity	☐ Not Hispanic/Latino ☐ Cuban ☐ Mexican/Mexican American/Chicano ☐ Puerto Rican ☐ 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

☐ No Insurance	*Financial assistance is available to those who qualify*		
☐ KanCare/Medicaid	ID # Aetna ☐ United Healthcare ☐ Sunflower ☐		
☐ Commercial/Private Insurance	*Insurance will be billed. Dependent upon your policy coverage, you may receive a bill. Financial assistance is available for those who qualify.*		
Insurance Company		Policy #	Group #
Subscriber Name			Date of Birth

Patient: To be completed by HPC		
Patient Account #	Slide Level	Date of Service

FINANCIAL ASSISTANCE AVAILABLE FOR 2024 – 2025 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	☐ $30,121 or greater
2	☐ $0 - $20,440	☐ $20,441 - $27,185	☐ $27,186 - $33,930	☐ $33,931 – $40,880	☐ $40,881 or greater
3	☐ $0 - $25,820	☐ $25,821 – $34,341	☐ $34,342 - $42,861	☐ $42,862 - $51,640	☐ $51,641 or greater
4	☐ $0 - $31,200	☐ $31,201 - $41,496	☐ $41,497 - $51,792	☐ $51,793 - $62,400	☐ $62,401 or greater
5	☐ $0 - $36,580	☐ $36,581 - $48,651	☐ $48,652 - $60,723	☐ $60,724 - $73,160	☐ $73,161 or greater
6	☐ $0 - $41,960	☐ $41,961 - $55,807	☐ $55,808 - $69,654	☐ $69,655 - $83,920	☐ $83,921 or greater
7	☐ $0 - $47,340	☐ $47,341 - $62,962	☐ $62,963 - $78,584	☐ $78,585 - $94,680	☐ $94,680 or greater
8	☐ $0 - $52,720	☐ $52,721 - $70,118	☐ $70,119 - $87,515	☐ $87,516 - $105,440	☐ $105,441 or greater
SFDP Level	**A**	**B**	**C**	**D**	**E**
	Eligible for Discounted Services				**Not Eligible**

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Initial Here

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.

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