Sea Mar
Community Health Centers
Clínica de la Comunidad
Exceptional service. Every person. Every time.

# Please fill out this form in its entirety.

| **Patient Name** (Last, First) | | **Date of Birth** (mm/dd/yyyy) | |
|---|---|---|---|
| **Address:** | **City:** | **State:** | **Zip Code:** |
| **Phone Number:**<br><br>**Email:**<br><br>**Marital Status:** | | **Emergency Contact:**<br><br>Name:<br><br>Relation: Phone: | |

**Race:**
- ☐ Asian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White/Latino
- ☐ White/Non-Latino
- ☐ Other Race

**Ethnicity:**
- ☐ Latino
- ☐ Non-Latino

**Latino Origin:**
- ☐ Cuban
- ☐ General Latino
- ☐ Mexican/Mexican-American/Chicano
- ☐ Other Spanish/Latino
- ☐ Puerto Rican
- ☐ Unknown

**Gender Identity:**
- ☐ Male
- ☐ Female
- ☐ Trans M/F
- ☐ Non Binary
- ☐ Other

**Preferred Language:**

**Veteran**
- ☐ Yes
- ☐ No

**Homeless**
- ☐ Yes
- ☐ No

**Farmworker**
- ☐ Yes
- ☐ No

## Income Information

Sea Mar requests this information from all patients for anonymous reporting purposes. Please circle the category that applies to you.

| Family Size | Income Level | | | | | |
|---|---|---|---|---|---|---|
| 1 | 0 - $12,880 | $12,881-$16,100 | $16,101-$19,320 | $19,321-$22,540 | $22,541-$25,760 | $25,761+ |
| 2 | 0 - $17,420 | $17,421-$21,775 | $21,776-$26,130 | $26,131-$30,485 | $30,486-$34,840 | $34,841+ |
| 3 | 0 - $21,960 | $21,961-$27,450 | $27,451-$32,940 | $32,941-$38,430 | $38,431-$43,920 | $43,921+ |
| 4 | 0 - $26,500 | $26,501-$33,125 | $33,126-$39,750 | $39,751-$46,375 | $46,376-$53,000 | $53,001+ |
| 5 | 0 - $31,040 | $31,041-$38,800 | $38,801-$46,560 | $46,561-$54,320 | $54,321-$62,800 | $62,081+ |
| 6 | 0 - $35,580 | $35,581-$44,475 | $44,476-$53,370 | $53,371-$62,265 | $62,266-$71,160 | $71,161+ |
| 7 | 0 - $40,120 | $40,121-$50,150 | $50,151-$60,180 | $60,181-$70,210 | $70,211-$80,240 | $80,241+ |
| 8 | 0 - $44,660 | $44,661-$55,825 | $55,826-$66,990 | $66,991-$78,155 | $78,156-$89,320 | $89,321+ |
| Other (Provide Write-In Household Size and Income): | | | | | | |

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# Notice of Privacy Practices Acknowledgement

The Notice of Privacy Practices for Protected Health Information describes how medical information about you may be used and disclosed, how you can get access to this information and who to contact if you have questions, concerns or complaints.

Sea Mar has the responsibility to protect the privacy of your information, provide a Notice of Privacy Practices, and follow information practices that are described in this notice. If you have any questions, please contact Sea Mar's Vice President of Corporate and Legal Affairs at 206.763.5277.

By signing this form, you acknowledge receipt of Sea Mar Community Health Centers' Notice of Privacy Practices and Patient Rights and Responsibilities. Sea Mar encourages you to review these notices carefully.

I acknowledge receipt of Sea Mar Community Health Centers' Notice of Privacy Practices and Patient Rights and Responsibilities.

| | |
|---|---|
| Patient or legally authorized individual signature | Date Time |
| Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative) |

Patient Name: <<PName>>
DOB: <<PDOB>>
Patient ID: <<PNumber>>
*This form will be retained in your medical record.*

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# Sliding Fee Scale Application

To comply with federal regulations and provide you a discount on Sea Mar services, it is necessary for you to fill out this form, answer some personal questions, and provide proof of income. Your answers will be kept on file and in strict confidence.

| Patient Name: | DOB: | Patient ID: |
|---|---|---|

| Household Size: | Annual Income: | ☐ I choose NOT to provide my income. |
|---|---|---|

☐ **I choose NOT to apply for the sliding fee scale.** Please sign and date below.

Signature _____ Date _____

☐ **I choose to apply for the sliding fee scale discount.** The sliding fee scale is available for all patients, regardless of insurance status. If you have insurance, the sliding fee scale discount can be applied to charges not covered by insurance. Please complete the entire form to determine eligible discount.

| Household Members | NAME | BIRTHDATE (MM/DD/YYYY) | HEALTH INSURANCE | RELATIONSHIP | SEA MAR PATIENT? |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |

| SOURCE OF INCOME | ANNUAL INCOME | For You | For Spouse | For Children | For Others | Sub Total |
|---|---|---|---|---|---|---|
| | Gross Wages, Salaries, Tips | | | | | $ 0.00 |
| | Social Security & Pensions | | | | | $ 0.00 |
| | Annuity & Veteran Benefits | | | | | $ 0.00 |
| | Child Support & Alimony | | | | | $ 0.00 |
| | Self-Employment & Other | | | | | $ 0.00 |
| | For "Other," please explain: | | | | | |
| | | | | | TOTAL | $0.00 |

By signing below, I agree to provide Sea Mar Community Health Centers with a proof of income for all persons listed above. Acceptable proof of income includes, but is not limited to, social security statements, paycheck stubs (two most recent), public assistance letter, tax return form, W-2 form, L&I check stub, unemployment check stub.

I understand that I will be asked to reapply for the sliding fee scale at least once a year so Sea Mar can maintain an updated application on file. I certify that the information provided is accurate and complete to the best of my knowledge. I understand that if I knowingly give false information that results in assistance for which I am not eligible, I will be subject to criminal prosecution. I give my consent to release any and all information from whatever source needed to verify the information I have given.

Signature _____ Date _____

**OFFICE USE ONLY**

Patient is eligible for Sliding Fee Scale: ☐ Yes ☐ No SFS Status (circle one): A B C D E F

POI Requested:_____ Initial: _____ POI Received:_____ Initial: _____

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# Community Demographic Form

Please complete the form below. If you have any questions or concerns, please ask your clinician during the appointment.

| Patient Name: | Patient ID: |
|---|---|
| Patient Preferred Name: | |
| Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____ | |

## Gender Identity

What sex were you assigned at birth on your original birth certificate (check one)?
☐ Male ☐ Female ☐ Intersex ☐ Decline to Answer

Do you think of yourself as (check one):
☐ Man
☐ Woman
☐ Female-to-Male (FTM)/Transgender Male/Trans Man
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Gender Queer, neither exclusively male or female
☐ Additional gender category/Other, please specify: _____
☐ Decline to Answer

## Sexual Orientation

Do you think of yourself as (check one):
☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual
☐ Something else, please specify: _____ ☐ Don't know ☐ Decline to Answer

## Migrant and Seasonal Farmworker Status

In the past two years, have you or a member of your family worked in agriculture/farming, forestry or fisheries as your/their main employment including, but not limited to: Preparing, irrigating or spraying the fields, nurseries, orchards; Planting, picking, sorting, packing or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, alfalfa, hay or other agricultural products; Planting trees, working with Christmas trees, picking pine needles or Spanish moss; Working on farms that produce chicken, ducks, turkeys, cows, goats, sheep, horses, fish, seafood, etc.?
☐ Yes ☐ No

In the past two years, have you or a member of your family established a temporary home in order to work in agriculture?
☐ Yes ☐ No

Have you or a member of your family stopped the need to establish a temporary home to work in agriculture because of disability or old age?
☐ Yes ☐ No

In the past two years, have you or a member of your family worked in agriculture on a seasonal basis without the need to establish a temporary home?
☐ Yes ☐ No

## Housing Status

Are you currently living with friends or family, in your car, in a shelter, in a hotel, or on the street? ☐ Yes ☐ No

If yes, please choose one of the following that best describes your current situation:
☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional Housing ☐ Decline to Answer

## Other Demographics

Are you a US Veteran? ☐ Yes ☐ No

## Patient Acknowledgement

I have read and understood the above information and declare the information furnished to be to be true and complete to the best of my knowledge.

_____ _____

Patient Signature Date