Caritas Clinics, Inc.

Saint Vincent Clinic 818 N. 7th Street Leavenworth, KS 66048
Phone: 913-651-8860 Fax: 913-682-4409

Duchesne Clinic 636 Tauromee Kansas City, KS 66101
Phone: 913-321-2626 Fax: 913-321-2651

To apply for services at Caritas Clinics, Inc. you are required to provide the following information:

- **Please return all information requested or your application will not be processed. The application is valid for two months. If the information requested is not returned within two months it will be shredded and you will have to start the eligibility process over.**

___ **Certification of Eligibility & Registration Forms must be completely filled out.**

___ **Proof of Identity:** Kansas driver's license, Kansas I.D. Card, U.S. passport, Permanent Resident I.D, Government ID

___ **Proof of income from household for the last four pay periods, must be current and in consecutive order.** We define a household based on the linear family. A linear family is defined as grandparents, parents, spouse, siblings, and children.

___ **If you are self-employed, you must provide**: a year to date profit and loss statement.

___ **Income from all other sources:** Enter on Caritas Certification of Eligibility Form-unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, disability payments, pension or retirement income, interest, dividends, rents, royalties, income from estates & trusts, educational assistance, alimony, child support, financial assistance from outside household, & other miscellaneous sources.

___ **Are you paying your own living expenses?** ☐ **Yes** ☐ **No** If not, please initial here _____ and provide a notarized signed and dated letter from the person who provides your assistance, explaining how much assistance they are providing to you. Please include address and phone number of person who is providing assistance.

___ **Last year Form 1040 Federal Income Tax return – all pages.** If you were **not eligible** to file taxes last year, please initial here_____ and complete **IRS Form 4506t**.

___ **Proof of Street Address in Leavenworth County:** Utility, cable, mail from state, county or city. PO Box isn't valid.

Once your application is approved you will be contacted about an appointment. On your first visit, please be prepared to provide a copy of your Kansas Drivers License or Kansas I.D. If you are not a citizen of the U.S., please bring your Resident Alien I.D.

I, _____, understand that this is not a guarantee that I will qualify for the program. I have provided, to the best of my ability, the above requested information. ____/____/_____
mm / dd / yyyy

You may call 913.651.8860 with any questions you have regarding this application.

Caritas Clinics, Inc.
Saint Vincent and Duchesne Clinics

PATIENT REGISTRATION FORM

Date Printed:	Patient ID:
Appointment Date:	PCP:

PATIENT INFORMATION

(Please give your photo ID to the receptionist.)

Patient's last name:	First:	Middle:	Title:	Marital status:

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:

Address:

☐ Doubling Up ☐ Homeless Shelter ☐ Institution ☐ Migrant ☐Not Permanently Housed ☐Other ☐ Permanently Housed ☐ Seasonal ☐Street ☐ Transitional ☐ Unknown

Email:				Veteran: ☐ Yes ☐ No	
SSN or TIN:		Home phone no.:		Cell phone no.:	
Photo ID Type:		Employed: ☐ Full Time ☐ Part Time ☐ Unemployed		Occupation:	
Photo ID Number:		Company Name:		Employer phone no.:	
Language:		Race: ☐Native American ☐Asian ☐Black ☐Hawaiian ☐White ☐Other		Preferred Contact no.:	
Require translation services? ☐ Yes ☐ No		Ethnicity: I consider myself to be Latino ☐ Yes ☐ No		☐ Home ☐ Cell ☐ Work	

Physician last seen:	Address:	Phone No.	Date of last visit

INCOME INFORMATION

Enter all persons living under one roof as reflected on most recent IRS Form 1040

Family Member Name	Relationship	Birth Date	Income	Pay Frequency

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. **I have read the "Outpatient Treatment Policies of Caritas Clinics, Inc." stated on the back of this form. I understand them or have had someone clarify anything to me I did not understand.** I agree to the terms stated in the "Policies" as stated on the back of this form. **I understand that if Saint Vincent Clinic finds that I have intentionally given false financial information, I will immediately forfeit my right to services.**

Patient signature _____ Date _____

Caritas Clinic staff signature _____ Date _____

Outpatient Treatment Policies of Caritas Clinics, Inc.

Saint Vincent and Duchesne Clinics

I UNDERSTAND THAT Caritas Clinics, Inc. **does not** offer services that are already covered by: Veteran's benefits, Medicaid, Medicare, HealthWave or private health insurance. I understand that all patients at Caritas Clinics, Inc. are seen by a Nurse Practitioner (APRN), Physician Assistant (RPA-C) or Volunteer Medical or Mental Health Professional who is licensed in the State of Kansas and supervised by the Caritas Clinics, Inc. Medical Director. I give PERMISSION for EVALUATION and TREATMENT for myself by these medical personnel.

I understand that I have the right to refuse any specific diagnosis or treatment service without jeopardizing my right to receive health services at the Clinic, but I also understand that certain medications will not be prescribed because of this refusal. I understand that health services **are not** based on an exact science, and I acknowledge that no guarantees have been made to me as to the results of any treatment services.

I hereby authorize Caritas Clinics, Inc. to retain, preserve and use for scientific or teaching purposes or dispose of, at their convenience, any specimen or tissue taken from my body during my treatment.

I understand that Caritas Clinics, Inc. **does not** provide emergency care, urgent care, walk-in services, worker's compensation, disability services, care for pregnancy or for those living outside of our geographic service area.

I understand that all files are kept confidential in their use by Caritas Clinics, Inc. staff and that my written consent is required for any release of information by Caritas Clinics, Inc. to other persons or agencies, except as required by law in cases of court orders, child abuse, life threatening situations, and national security issues. In court ordered evaluations, any and all relevant information, including previously obtained material, may be released to the court. The staff is required by law to report **ANY** suspicion of child, adult, elder or vulnerable person abuse, including neglect, or emotional, physical, or sexual abuse.

My financial or statistical information may be released to funding sources which directly benefit me or assist Caritas Clinics, Inc. in providing services.

In an apparent life-threatening situation, I will be taken to a hospital emergency room by ambulance. Payment for ambulance services, emergency services and emergency room care will be my responsibility.

I agree to be considerate of the rights of other patients and Caritas Clinics, Inc. personnel and volunteers and to be respectful of the property of other persons and the Clinic.

- I agree to provide **all financial information on a yearly basis** based on my birth month in order to qualify for Clinic services. I agree to immediately notify Caritas Clinics, Inc. if my financial situation changes during the year and I become ineligible for Clinic services. _____ (initials)

- I agree to **pay something** for an office visit each time I visit the Clinic. I understand that an additional fee will be charged for some tests, medications and referrals. _____ (initials)

- I understand that Caritas Clinics, Inc**. is not responsible for any bills** incurred outside its services, such as emergency room visits, outpatient or inpatient hospital care, expensive diagnostic tests, or expensive ongoing medications or medical supplies. _____ (initials)

- If I am unable to keep a referral appointment, I am **REQUIRED** to cancel the appointment with the doctor's office/hospital prior to the appointment time. If I fail to cancel, I will lose all referral privileges for one year. _____ (initials)

I may be referred to a specialist for consultation. Specialists may volunteer services or charge a fee for the visit. A referral is for ONE office visit only. Payment for tests or procedures ordered by a specialist is my responsibility; therefore, I will discuss such payment with the specialist in advance. I understand I should not expect the specialist to provide ongoing help unless I am willing to pay for it.

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CERTIFICATION OF ELIGIBILITY

NO PATIENT WILL BE SEEN AT EITHER CLINIC WITHOUT WRITTEN PROOF OF INCOME

NAME _____
Last First MI

1. What is the **gross** monthly income of your household? _____
2. How many persons are supported by this income? _____
3. If you have any of the following health coverage, please check:
   Medicare _____ Medicaid _____ HealthWave/Medical Card _____
   Veteran's Benefits _____ Other _____ I have no health insurance _____

Family Size	Category A	Category B	Category C	Category D
1	$0 – $ 5,885	$ 5,886 – $11,770	$11,771 – $17,655	$17,656 – $20,598
M.	$0 – $ 490	M. $ 491 – $ 981	M. $ 982 – $ 1,471	M. $ 1,472 – $ 1,716
2	$0 – $ 7,965	$ 7,966 – $15,930	$15,931 – $23,895	$23,896 – $27,878
M.	$0 – $ 664	M. $ 665 – $ 1,328	M. $ 1,329 – $ 1,991	M. $1 ,992 – $ 2,323
3	$0 – $10,045	$10,046 – $20,090	$20,091 – $30,135	$30,136 – $35,158
M.	$0 – $ 837	M. $ 838 – $ 1,674	M. $ 1,675 – $ 2,511	M. $ 2,512 – $ 2,930
4	$0 – $12,125	$12,126 – $24,250	$24,251 – $33,375	$36,376 – $42,438
M.	$0 – $ 1,010	M. $ 1,011 – $ 2,021	M. $ 2,022 – $ 3,031	M. $ 3,032 – $ 3,536
5	$0 – $14,205	$14,206 – $28,410	$28,411 – $42,615	$42,616 – $49,718
M.	$0 – $ 1,184	M. $ 1,185 – $ 2,368	M. $ 2,369 – $ 3,551	M. $ 3,552 – $ 4,143
6	$0 – $16,285	$16,286 – $32,570	$32,571 – $48,855	$48,856 – $56,998
M.	$0 – $ 1,357	M. $ 1,358 – $ 2,714	M. $ 2,715 – $ 4,071	M. $ 4,072 – $ 4,750
7	$0 – $18,365	$18,366 – $36,730	$36,731 – $55,095	$55,096 – $64,278
M.	$0 – $ 1,530	M. $ 1,531 – $ 3,061	M. $ 3,062 – $ 4,591	M. $ 4,592 – $ 5,356
8	$0 – $20,445	$20,446 – $40,890	$40,891 – $61,335	$61,336 – $71,558
M.	$0 – $ 1,704	M. $ 1,705 – $ 3,408	M. $ 3,409 – $ 5,111	M. $ 5,112 – $ 5,963
Add for each additional family member				
	+$2,080	+$4,160	+$6,240	+$7,280

This information is correct and I provide it in order to receive care under the Charitable Health Care Provider Program. (K.S.A. 75-6120). **I understand that if Caritas Clinics, Inc. finds that I have intentionally given false financial information, I will immediately forfeit my right to services.**

_____ _____
Date Signature of Applicant or Parent or Guardian of Applicant

When/If you file taxes can you mark yourself as Head of Household? ☐ Yes ☐ No

If not, who is:_____

List ALL sources of GROSS MONTHLY INCOME (Before Taxes) for your household:

	Amount
a. Employment (include tips)……	_____
b. Unemployment Compensation…….	_____
c. Worker's Compensation……..	_____
d. Food Stamps……	_____
e. Alimony……..	_____
f. Child support……..	_____
g. Pension……	_____
h. Social Security……	_____
i. SRS Income (Cash Assistance)……	_____
j. Housing from friends, family or shelter…..	_____
k. Utilities from friends, family or shelter…..	_____
l. Support from friends, family, etc……	_____
m. Other _____	_____

TOTAL GROSS MONTHLY INCOME

$_____

Include the income of all adult family members. A family is defined as a group of two or more people who reside together and who are related by birth, marriage or adoption. Family income includes that of the parents and/or step-parents, unmarried or domestic partners, or caretaker relatives living under the same roof.