

Patient Registration/ Income Verification

Lower Lights Christian Health Center
1251 W. Broad St.
Columbus, Ohio 43222

Name _____ DOB _____
Address _____
Home Phone _____ Cell/Work phone _____

Income verified: Date: _____ Initials: _____
No Income Verified: Date: _____ Initials: _____
Medicaid Eligibility: Eligible: _____ Not Eligible: _____ Pending: _____
Referral made for Benefit Bank: _____
Reviewed Office Policy for Non-payment: Date: _____ Initials: _____
Reviewed Office Policy for No-Show: Date: _____ Initials: _____

Number of adults living in the home _____
Number of children 18 and under in home _____
Your gross monthly earned income _____
Your gross monthly unearned income (Child support, alimony, SSI, etc.) _____

Financial Determination:

Pt. has _____ Medicaid _____ Medicare _____ Commercial Insurance _____ No Coverage

Sliding Fee: _____ \$10.00 _____ \$20.00 _____ \$30.00 _____ \$50.00 _____ Full Fee
Lab fee: _____ \$5 _____ \$7 _____ \$9 _____ \$12 _____ Indigent _____ Medicaid Pending
Effective Dates _____ to _____

Check stub, tax return or disability award letter copied and attached? Yes _____ No _____

If check stub not copied and attached, please check reason:
_____ First time visit/unaware of requirements (60 day limit-one time use)
_____ No income (If checked, attach no income form)
_____ Proof filed under another patients chart (eligibility and expiration the same as patient with proof filed) Name of chart _____

I agree to pay my fee at the time of service. I further attest that, as of the date of my signature, the income source listed constitutes my entire household income, and that the family members listed are all solely dependent on that income.

Signature Patient _____ Date _____

Signature of Case Manager _____ Date _____

Front Desk:

Date received: _____
Date all requested fields entered: _____
Staff Initials: _____