Promise Healthcare

Patient Information (Please present your Photo Identification and insurance card with this paperwork)

Legal Name: First | Middle | Last | Suffix (Jr, Sr, II, III etc.)

Date of Birth: _____/_____/_____	Social Security #	Patient Sex as listed on Insurance/Driver's License /State ID ☐ Male ☐ Female

Street Address	Apt/Ste/Unit	City	State	Zip

Mobile/Cell Phone ( )	Home Phone ( )	Email address

Best way to contact me/leave messages (check all that apply): ☐ Phone/voicemail ☐ E-mail/Patient Portal ☑ SMS Text

Preferred Pronoun ☐ Asked but unknown ☐ He, Him, His ☐ She, Her Hers ☐ They, Them, Theirs ☐ Ze, Hir ☑ Other ☑ Declined

How would you (patient) describe your Gender Identity:

- ☐ Female
- ☐ Male
- ☐ Female to Male (FTM) Transgender Male
- ☐ Male to Female (MTF) Transgender Female
- ☐ Choose not to disclose
- ☐ Other:_____

Sexual Orientation:

- ☐ Lesbian or Gay
- ☐ Heterosexual (or straight)
- ☐ Bisexual
- ☑ Something else
- ☑ Choose not to disclose
- ☑ Don't know

Marital Status ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Separated ☑ Widowed ☐ Other:

Preferred Language ☐ Burmese ☐ English ☐ French ☐ German ☐ Japanese ☐ Italian ☐ Spanish ☐ Guajarati ☐ Kanjobal ☐ Tigrinya ☐ Sudanese ☐ Other:

Student Status ☐ Full-time ☐ Part -time ☐ Not a Student

Responsible Person for Bill - If 'Self' leave blank

Relationship ☐ Self ☐ Parent ☐ Life Partner ☐ Spouse ☐ Other:_____

Legal Name: First	Middle	Last	Suffix (Jr, Sr, II, III etc.)

Street Address	Apt/Ste/Unit	City	State	Zip

Date of Birth _____/_____/_____	Social Security #	

Insurance Information

Primary Insurance Name: ☐ Medicare ☐ Medicaid ☐ BCBS ☐ Molina ☐ United Healthcare ☐ Other:

Name of Policy Holder:	ID Number: Group Number:	Policy Holder date of birth: _____/_____/_____

Relationship: ☐ Self ☐ Parent ☐ Life Partner ☐ Spouse ☐ Other:

Secondary Insurance Name: ☐ Medicare ☐ Medicaid ☐ BCBS ☐ Molina ☐ United Healthcare ☐ Other:

Name of Policy Holder:	ID Number: Group Number:	Policy Holder date of birth: _____/_____/_____

Relationship: ☐ Self ☐ Parent ☐ Life Partner ☐ Spouse ☐ Other:

Housing and Worker Status

Homeless Status: ☐ Doubling ☐ Not Homeless ☐ Transitional ☐ Unknown (Homeless) ☐ Street ☐ Shelter ☐ Other (Homeless) ☐ Permanent Supportive Housing

Promise Healthcare

Employer Information			
Employer Name:			
Employer Street Address:	**City**	**State**	**Zip**
Work Phone:	**Occupation:**		
Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed			

Emergency Contact/ Relations/Role				
Legal Name: First	**Middle**	**Last**	**Suffix (Jr, Sr, II, III etc.)**	
Street Address **Apt/Ste/Unit**		**City**	**State**	**Zip**
Mobile/Cell Phone ( )	**Home Phone** ( )	**Relationship to Patient**		

Migrant Worker Status

☐ Migrant ☐ Not a Farm Worker ☐ Seasonal Worker

Race:

☐ Asian Indian ☐ Chinese ☐ Native Hawaiian ☐ White ☐ Asian
☐ Vietnamese ☐ Other Asian ☐ Filipino ☐ Japanese ☐ Korean
☐ American Indian/Alaskan Native ☐ Black/African American ☐ Other Pacific Islander ☐ Samoan ☐ Guamanian or Chamorro

Ethnicity:

☐ Hispanic ☐ Not Hispanic ☐ Chicano ☐ Cuban ☐ Other Hispanic
☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Spanish

Veteran Status:

- **Active Duty** ☐ Yes ☐ No
- **If 'No,' Retired Date:** ☐ Yes ☐ No _____

Sliding Fee Scale and Financial Agreement

Current Household Income: ☐ Weekly $_____ ☐ Monthly $_____ ☐ Annually $_____

How many people live in your household? _____

PHC receives funding to provide financial benefits to clients. By providing your proof of your income PHC can determine whether you are eligible for these benefits.

Proof of your income includes, but is not limited to, your last two to three pay stubs, last year's W-2 form, last year's tax return or paperwork approved by a PHC financial counselor.

By signing, I understand that:

- Based on my income, I may be eligible for the PHC sliding scale. However, I must provide proof of income to receive these benefits within 30 days of my first visit.
- I understand that I will be charged the full fee for my visit if I do not bring in documentation of income within 30 days of my first visit.
- I understand that I am financially responsible for the copayment / deductible that my healthcare coverage indicates or if I do not have insurance, I will be responsible for the charges less any income-based discounts I might qualify for.
- I understand that non-payment may result in my account being forwarded to an outside collection agency. All collection fees incurred will be my responsibility. I agree that this authorization covers all services rendered.
- I understand that I will never be refused services at PHC due to failure to pay.

Patient Signature: _____ **Date :**_____

Form revised 03/18/2024

Promise Healthcare

Minor Consent for Treatment

Minor's full name: _____ Date of Birth: _____

A physician, nurse practitioner or physician assistant, dentist, dental hygienist, nurse, psychiatrist, and mental health counselor are available, based on schedule to provide primary healthcare, dental care, psychosocial services, and nutritional consultations.

Available services may include, but are not limited to:

- Physical examinations, health assessments, and/or screening for health problems
- Diagnosis and treatment of acute illness and injury
- Diagnosis and management of chronic illness
- Health education and promotion: outreach health promotion /prevention workshops will be offered
- Immunizations
- Wellness promotion including smoking cessation, nutrition, and/or weight management
- Reproductive health care including gynecological examinations, STD education, testing and treatment, HIV/AIDS education, counseling/testing, and contraceptive services
- Laboratory tests including throat culture, complete blood counts, mono spots etc.
- Mental health counseling services
- Dental examination and treatment
- Referrals to other agencies for services not provided at the School Based Health Center.

By signing below, I certify and affirm that:

The aforementioned child has my consent to receive services offered by Promise Healthcare by its providers. I have been informed of and understand the scope of services which may be provided. I also understand that a parent, legal guardian, or minor who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care service(s). I also understand that although I am encouraged to be present for appointments, it is not required and that by signing below, I am authorizing Promise Healthcare to provide services to my child in his/her best interest.

I further understand that under Illinois law, a minor over age 12 has the same capacity as an adult to consent to certain health services and no parent is required for such services.

I understand that if my child is 12 or older and were to receive mental health/substance abuse services from Promise Healthcare, he/she/they may receive up to eight therapy sessions without my consent. By law, a child under age 12 will not be allowed to receive mental health/substance abuse services without parental consent.

This consent shall be effective from the date of signature for one year unless I terminate it in writing or at such time that the minor turns eighteen (18) or otherwise becomes emancipated.

Parent/guardian printed full name: _____

Relationship to minor: _____

If/when I am not available, I authorize the following person(s) to accompany this child to their appointment(s) if applicable:

Full Name: _____ Relationship to Child: _____

Full Name: _____ Relationship to Child: _____

Full Name: _____ Relationship to Child: _____

Parent/guardian signature: _____ Date: _____

Patient signature (12 years or older): _____ Date: _____

STAFF USE ONLY

Received by: _____ Date Received: _____

Promise Healthcare

HIPAA Authorization Form

Who can discuss your Medical Information?

Patient Name:_____ Date of Birth: _____

About this form:

- This form allows those listed below to have information about your medical care and/or payment either verbally in person or via telephone.
- This form allows Promise Healthcare to inform those listed below (or a disaster relief organization) of your location, health or death.
- This form does **NOT** replace the 'Release of Information' form which allows for copies of medical records.

☐ I **do not** wish to authorize Promise Healthcare to discuss my medical information with anyone.

THESE PEOPLE CAN HAVE MY HEALTH INFORMATION:		
1. Name:		Relationship to you:
Phone #:	Street Address:	
City:	State:	Zip Code:
2. Name:		Relationship to you:
Phone #:	Street Address:	
City:	State:	Zip Code:
3. Name:		Relationship to you:
Phone #:	Street Address:	
City:	State:	Zip Code:

APPROVED TYPES OF INFORMATION:			
☐ All Information	☐ Appointment Information	☐ Lab Results	☐ Testing Results
☐ Billing Information	☐ Treatments	☐ Dental Services	☐ Other:_____ _____

By signing, I allow Promise Healthcare to talk about my (or my dependent's) health information to the person listed above. I understand that this form does NOT replace the 'Release of Information,' and does not allow those listed above to receive copies of my medical records.

Patient/Parent/Guardian Signature: _____ Date: _____

Promise Healthcare

HIPAA Authorization Form (cont.)

SENSITIVE MEDICAL INFORMATION TO BE RELEASED (Initial and Date Required for Each Item):

I understand that the information approved above may contain sensitive medical information that requires my specific consent in order to be discussed. By initialing each item, I specifically authorize Promise Healthcare to talk about the following sensitive topics with the people listed on this form:

☐ Mental/Behavioral Health	Initials: _____	Date: _____
☐ Alcohole/Drug Abuse	Initials: _____	Date: _____
☐ Genetics	Initials: _____	Date: _____
☐ Reproductive Care	Initials: _____	Date: _____
☐ HIV/AIDS/Sexually Transmitted Diseases	Initials: _____	Date: _____

Please Note: The following medical information of a patient 12 – 17 years of age (minor patient) is restricted as follows:

Drug/alcohol use, reproductive health, AIDS/HIV, other sexually transmitted disease(s), birth control, sexual assault, as well as any health information generated as a result of the minor patient's independent, legally authorized consent to treatment, requires the minor patient's signature to discuss.

Information in mental health or developmental disabilities will be available after the minor patient's signature, provided the minor patient has been informed and does not object to disclosure. Otherwise, Illinois law only permits limited mental health or developmental disabilities information to be available to the Minor patient's parent or guardian.

If patient is a minor, (age 12-17) Promise Healthcare requires an adult to witness the signing.

Patient/Parent/Guardian Signature:	Today's Date:
Witness Signature:	Today's Date:
Witness Name (printed):	Witness phone #:
Witness Relationship to Patient:	

This authorization will be valid as long as the patient remains a patient of Promise Healthcare unless patient designates an expiration date or revokes the authorization in writing. If patient fills out multiple versions of this form, all previous versions of this form are void and only the newest form with the most recent date of signature is accepted. If the patient is a minor at time of signature, this authorization expires upon the minor's age of majority.

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice applies to all Promise Healthcare locations.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We may ask you to make the request in writing.

• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

• You can ask us not to use or share certain health information for treatment, payment, or our operations.

• We are not required to agree to your request, and we may say "no" if it would affect your care.

• If you pay for a service or health care item out- of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

• We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

• You can complain if you feel we have violated your rights by contacting us using the information on the last page of this notice.

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting www.hhs.gov/ocr/privacy/hipaa/ complaints/.

• We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care.

• Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

• Marketing purposes

• Sale of your information

• Most sharing of mental health notes

In the case of fundraising:

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Other Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you.

• We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

• We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

• We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

The examples used in this Notice of Privacy Practices are illustrations only and not meant to be a complete list.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues.

• We can share health information about you for certain situations such as:

• Preventing disease

• Helping with product recalls

• Reporting adverse reactions to medications

• Reporting suspected abuse, neglect, or domestic violence

• Preventing or reducing a serious threat to anyone's health or safety

Do research.

• We can use or share your information for health research.

Comply with the law.

• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests.

• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director.

• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests.

• We can use or share health information about you:

• For workers' compensation claims

• For law enforcement purposes or with a law enforcement official

• With health oversight agencies for activities authorized by law

• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions.

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Federal law privacy protections and state law privacy protections

HIPAA generally does not preempt or override other laws that give people greater privacy protections. If any applicable state or federal law requires us to provide you with more privacy protections, then we must follow that law in addition to HIPAA.

Some types of health information may have additional protection under federal or state law. For example, some genetic test results, mental health records, HIV / AIDS test results, educational records, and federally assisted alcohol and substance abuse treatment programs are subject to special restrictions on our use and disclosure under various laws.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

• We must follow the duties and privacy practices described in this notice and give you a copy of it.

• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

If you have any questions or would like further information about this Notice of Privacy Practices, please contact Promise Healthcare's Privacy Officer at 217-356-1558

Patient Bill of Rights

Promise Healthcare works with you to exceed your expectations. We respect your rights to healthcare access, equity, and safety, and your privacy is our priority. Your rights, your responsibilities, and our pledges to you are listed below.

You have the right to:

- Receive respectful care regardless of your sex, age, race, religion, color, national origin, sexual orientation, or any other personal characteristics, including your primary source of payment.
- Be treated with consideration for your emotional, spiritual, and cultural needs.
- Be fully informed of available services at Promise Healthcare, including after-hours and emergency care and fees for all services.
- Expect reasonable continuity of care and have a provider who manages your care.
- Request a second opinion when you believe it is necessary.
- Know the names and positions of people involved in your care by official name tag or personal introduction.
- Have a reasonable choice of providers and information about your options. You can change providers if you are dissatisfied with your care using our procedure for changing providers. Please ask the front desk for help.
- Seek help, such as a wheelchair or interpreter, to obtain care easier.
- Receive the information about your health in a way that you can understand, take part in decisions about your care, and give your informed consent before any procedure is performed as per Illinois law.
- Be made aware of any unanticipated outcomes.
- Fully take part in the decision-making process about your care. You may have parents, guardians, family members, civil union partners, or other individuals that you choose to be involved.
- Refuse a recommended treatment, to the extent allowed by law, and be informed of the risks associated with and potential consequences of refusing to be treated.
- Expect that your health record will be kept confidential. For more information about your right to privacy, please review your HIPAA and Notice of Privacy statements.
- Ask and receive an explanation of any charges made by Promise Healthcare, even if they are covered by insurance.
- Complete an advance directive for end-of-life care. Please let your care team know if you are interested in learning more about advance directives.
- Express any complaints or concerns through our patient grievance/comments form.

As part of our contract with you, we pledge to:

- Provide you with ethical treatment by caring and qualified healthcare providers.
- Provide services that are available to you as you need them.
- Provide emergency coverage and provider availability on call, 24 hours a day, 7 days a week by calling our office number. When the office is closed, the provider may consult with you by phone.
- Always deal with you honestly and openly.

- Provide you with financial help based on a sliding-fee scale. This is dependent upon your income.
- Provide you with a confidential and detailed explanation of your bill of services.
- Participate in measures to always ensure patient safety.

You have a responsibility to:

- Arrive on time for scheduled appointments and tell us if you are going to be late. If you are late, we cannot guarantee your appointment. Call us at least 24 hours in advance if you need to cancel or reschedule.
- Provide us with at least 48 hours' notice when you or a family member needs medications or a prescription.
- Follow all rules and regulations posted within Promise Healthcare.
- Speak and behave respectfully to Promise Healthcare staff and other patients.
- Respect the privacy and confidentiality of other patients.
- Turn off cell phones in clinical areas.
- Provide us with all needed information so we can keep an accurate file for you. This includes reporting any changes to your address, telephone number, status of advance directives, and if necessary, financial status.
- Pay your bills at the time of service including co-payments and deductibles or arrange a payment plan if needed.
- Provide honest and complete information about your health concerns, past health medical history, medications, and unexpected changes in your health so that we can provide you with the highest level of care.
- Provide us with medical records upon request.
- k questions if you do not understand any information or instructions, we give you.
- Develop a treatment plan with your care team and follow it to the best of your ability. Be honest about what you have been able to do (or not do) when seen in follow-up. If you are unable to follow a treatment plan, we will do our best to help you find out why to change the plan or correct the problem if possible.
- Supervise children that are in your care.
- **Please note:** Making harassing, offensive, or intimidating statements or threats of violence could result in your removal from Promise Healthcare. If you are removed from one of our offices, you are considered removed from all Promise sites.

Promise
Healthcare

'Notice of Privacy Practices' Acknowledgement

By signing below, I acknowledge that I received a copy of the 'Notice of Privacy Practices.'

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

'Patient Bill of Rights' Acknowledgement

By signing below, I acknowledge that I received a copy of the 'Patient Bill of Rights.'

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

Promise Healthcare

Promise Healthcare Application for Sliding Fee Scale Discount

If you need assistance completing any part of this application, please talk with a Promise Healthcare staff member.
Only one form is necessary per household

Is your medical coverage through Medicaid or a Medicaid managed care plan? ☐ Yes ☐ No
If YES, skip this form and verify income on our Medicaid form.

Applicant Name: _____ Birthdate: _____ Social Security Number: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone Number: _____ Alternate Phone Number: _____

Email Address: _____

Do you or does someone in your family have medical insurance? ☐ Yes ☐ No

Do you or does someone in your family have dental insurance? ☐ Yes ☐ No

If yes, please complete below. Add additional sheets as necessary.

Medical Insurance Company Name: _____

Policy #: _____ Group #: _____ Subscriber #: _____

Company Address: _____ City: _____ State: ____ Zip: _____

Dental Insurance Company Name: _____

Policy #: _____ Group #: _____ Subscriber #: _____

Company Address: _____ City: _____ State: ____ Zip: _____

Are you a U.S. veteran? ☐ Yes ☐ No

Within the last 24 months, have you worked or are you the dependent of someone who has worked in agriculture, either on a farm or in an agricultural-based industry? ☐ Yes ☐ No

If yes, which applies?

☐ Migrant (establishes temporary residence in area)

☐ Year-Round Employment (permanent residence in area)

☐ Seasonal Permanent Resident (permanent resident in area)

Type of Housing (check one)

☐ Rent or own home

☐ Homeless Shelter

☐ Doubled Up (live with another person or family unit)

☐ Transitional (live place to place)

☐ Street

☐ Other

List all dependents (if more than 6 dependents, please list on separate page)

Name and Social Security Number	Date of Birth	Relationship to Applicant	Do They Have:	
			Medicaid	Other Insurance

Income Summary Table

Sources	Total Household Income	Accepted Documentation
Wages		Last federal income tax return or last two paycheck stubs prior to the signature date on this application.
Interest/Dividend Income		Bank, credit union, savings statement or 1099.
Self-Employment, Rental Income		Ledger of income and expenses for the current year.
Public Assistance, Social Security/Disability		Award letter(s) listing amount received in the current year. If you receive more than one, please add them together.
Unemployment Compensation		Unemployment compensation benefit award letter for the current year.
Workers Compensation		Worker's compensation benefit award letter for the current year.
Child Support, Alimony		Divorce decree stating child support or alimony received.
Retirement Pension		Letter supplied by system administrator with monthly benefit amount for the current year.
Assistance from Family/Friends		A notarized statement from family or friends explaining any financial help that they give you.
Other (Specify)		
Total		

Number of people supported by household income: _____

If you have any additional documents that may help Promise Healthcare make a determination regarding your application, please include them with this application.

Patients who qualify for certain levels of sliding fee discounts are expected to also apply for other programs if requested to do so including Medicaid, other public and/or private health insurance and/or discount programs available for which you may qualify, including prescription drug assistance from pharmaceutical companies.

Although a patient's inability to pay for services will not prohibit services being provided, a patient who refuses to pay even though able to pay will be subject to collection activities. Patients are expected to be in compliance with Health Resources and Services Administration/Bureaus of Primary Health Care policies and regulations in order to receive medical services.

I understand that all of the information given may be confirmed by Promise Healthcare. I also understand that providing false information is considered fraud and will result in a denial of the Sliding Fee Scale Program application and that I will owe the charges for the services provided. I understand that if I am approved, the discount is good for one year from the date of the application and that I will need to complete another application at that point in order for the discount to continue. I also understand that if I am approved for the discount, I am obligated to inform Promise Healthcare if my financial situations improve, so that Promise Healthcare can re-evaluate my eligibility for the discount.

Applicant Signature (required): _____ Date: _____

Promise Healthcare Internal Use Only:

Total Income: _____ Number in Household: _____

Staff Signature: _____ Date: _____