FINANCIAL SCREENING FORM

sunrise COMMUNITY HEALTH

HEAD OF HOUSEHOLD

Name: Last Name: First Name: Middle Name: **Email Address**

Physical Address: Street /Apt # City State Zip County **Mailing Address**: Street /Apt # City State Zip

Home/Cell Phone Number: **Work Phone Number:** **Preferred Language Spoken:** **Emergency Contact:** Name, Address & Phone Number

Do you prefer that we contact you by ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ In person.

We may call, text, or leave you a voice message. please let us know if you would like to opt out of text appointment reminders ☐Yes ☐ No

	LEGAL NAME Last, First, Middle	How is this person related	Social Security Number	SEX (male/female/ transgender male or female/decline	Date of Birth	Pregnant Y/N	Health Insurance Y/N	Marital Status	Job Title /Retired/ Disabled/ Student/ Unemployed	Pronouns (She/Her He/Him)	Sexual Orientation (Straight/Lesbian/Gay/Bisexual/ decline)	Office use only PM ID
1		Self										
2												
3												
4												
5												
6												

Additional Information - Please take a moment to answer the following questions as they apply to you; they are very important to keep our funding options for providing patient care at reduced costs. We will not report your name or address as part of this process or any personal information.

Are you a veteran ☐ Yes ☐ No Is anyone listed above a veteran ☐ Yes ☐ No Name: _____

1. Anytime during the past 24 months have you or a member of your family been hired to do agricultural work? ☐ Yes ☐ No

If you entered YES to the above question, are you a: ☐ Seasonal worker ☐ Migrant Worker ☐ Seasonal agricultural work year-round ☐ Retired or disabled migrant/seasonal worker

2. Do you consider yourself homeless? ☐ Yes ☐ No If you entered YES, are you ☐ Living on the street ☐ Transitional housing ☐ Shelter ☐ Other _____

3. Monthly Household Income $_____. Pay days are: ☐ Weekly ☐ Biweekly ☐ Twice a month ☐ Monthly ☐ **Number of people this income supports?** _____

4. Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer not to report

5. Race ☐ American Indian/Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Guamanian or Chamorro ☐ Samoan ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Other _____ ☐ Prefer not to report

6. How did you hear About Sunrise? ☐ Internet ☐ Word of Mouth ☐ Patient ☐ Physician/Hospital ☐ 211 ☐ Newspaper ☐ Other _____

Consent for treatment and consent to bill my insurance

I acknowledge and consent to the health care services rendered at this facility. I understand that I am responsible for making my co-payment. I agree to pay co-payments at the time of service unless other arrangements have been made in advance. I authorize the release of any medical/dental information necessary to secure the payment of benefits and authorize the use of this signature on all my insurance submissions. I also understand that in the event that my insurance or discount doesn't cover a service that I am responsible to pay for any denied claims or non - covered benefits.

Signature _____ **Date** _____ **Signature of Spouse** _____ **Date**_____