Medicaid Patient Registration Form

CrossOver Healthcare Ministry

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Email:	
Social Security #: If none, write N/A		Sex: ❑ Male ❑ Female ❑ MTF ❑ FTM	
Country of Origin:	Date of Birth: *(MM/DD/YYYY)* ____/____/_____		
Marital Status:			
Emergency Contact Name:	Emergency Contact Phone #:		
Relationship to Patient:	How were you referred to CrossOver?		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:
Date of Birth:	Phone:
Alternate Phone:	
Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Race (please select):

- ☐ White
- ☐ Hispanic
- ☐ Other
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Decline
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander

Ethnicity (please select one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline

Preferred Language (please select one): ☐ English ☐ Arabic ☐ Pashtu ☐ Indian (including Hindi & Tamil) ☐ Spanish ☐ Portuguese ☐ Dari ☐ Farsi ☐ Other

Preferred Pharmacy Name & Location:	**Pharmacy Phone #:**

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I have reviewed a copy of CrossOver Healthcare Ministry's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X _____ **Date:** _____

Printed Name of Responsible Party: X _____ **Date:** _____

CROSSOVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

HIPAA – Patient Acknowledgment Form

Patient's Name: _____ DOB: _____

Our Notice of Privacy Practices (NPP) provides information about how CrossOver Healthcare Ministry may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patients' Rights section describing your rights under the law.

Please review the NPP pamphlet thoroughly before signing this acknowledgement form. In the event that terms of the Notice change, a revised copy will be made available to you. By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment, and healthcare operations. You have the right to restrict how PHI is used or disclosed for treatment, payment or healthcare operations.

By signing this form, I also give permission to the person(s) listed on the table to receive Private Health Information (**excluding mental health information)** and other authorizations as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting my request to change, add, or terminate such permission in writing.

Name of Individual and relationship to patient	Telephone	Check for permission or write comment.
		☐ Medical/dental/vision record pick up ☐ Request appointment or clinical information ☐ Medical equipment pick-up ☐ Other:_____
		☐ Medical/dental/vision record pick-up ☐ Request appointment or clinical information ☐ Medical equipment ☐ Other:_____

I give permission for CrossOver Health Care Ministry to leave a message (voice/text) on _____ for:

- ☐ appointment reminder
- ☐ lab/imaging results
- ☐ other:_____

For the continuity of your health care, do you authorize us to share your health information with other health care providers through PRIZMA, a shared information platform? ☐ Yes ☐ No

Please check off the boxes below:

- ☐ I assume responsibility to inform the practice of any changes in the above information.
- ☐ I have received the most recent Notice of Privacy Practices (NPP).
- ☐ I have received the most recent Patient Resource Guide.
- ☐ I hereby authorize a CrossOver Healthcare Ministry representative to sign my name or make corrections on the necessary Access Now form(s) that may be required to maintain continuity of my healthcare.

Patient's Signature: _____Date: _____

Relationship to patient if other than self: _____

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COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

We want to make sure that we provide the best care possible. Below are some non-medical questions to support your health goals and meet your needs. Your responses are completely confidential.

TODAY'S DATE: _____

Full Name: _____ **Date of Birth:** _____

Social Determinants of Health

1. Are you having difficulty affording food or need assistance with food stamp application? ☐YES ☐NO
2. Are you having trouble affording a place to live? ☐ YES ☐ NO
3. Are you experiencing anxiety or depression? ☐ YES ☐ NO
4. Are you having family trouble which might be affecting your health? ☐ YES ☐ NO
5. Are you or your children having trouble in school? ☐ YES ☐ NO ☐ Not Applicable
6. Do you ever feel unsafe in your home for any reason? ☐ YES ☐ NO
7. Do you have access to Internet? ☐ YES ☐ NO

Our staff is available to assist with your social needs by connecting you with resources. *If you answered <u>YES</u> to questions 1-6, would you like an appointment?* ☐ YES ☐ NO

Patient Health Questionnaire – PHQ2

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

- ☐ **0** = Not at all
- ☐ **1** = Several days
- ☐ **2** = More than half the days
- ☐ **3** = Nearly every day

Feeling down, depressed, or hopeless

- ☐ **0** = Not at all
- ☐ **1** = Several days
- ☐ **2** = More than half the days
- ☐ **3** = Nearly every day

☐ *I decline to answer questions*