Long Island Select Healthcare

Eligibility Determination
For Sliding Fee Discounts

Do you want to apply for cheaper appointments? It is the policy of Long Island Select Healthcare, Inc. (LISH, Inc.) to provide essential services to all patients regardless of the patient's ability to pay. Discounts are set by the LISH consumer Board of Directors and are offered based on the information you provide regarding your family size and income. If you are eligible for a sliding fee discount, it will apply to all services received at LISH, but not for those services provided outside the Health Center.

Please complete the following information, even if you have insurance.

Household Income Before Taxes

Household Member	Number	Monthly Income	Yearly Income
Your name:			
Spouse name:			
Dependent children			
Other dependents			
Total			

☐ I decline to provide information on my income and family size and agree to pay the full LISH fee.

☐ I agree to provide proof of income at my next visit.

Acceptable proof of income is required for the sliding feediscount program.
If your financial situation changes, please keep LISH informed.

I certify that all information shown above is true, accurate, and correct. I understand that if LISH determines that I misrepresented or falsified information, I will no longer receive discounts and may be asked to pay back discounts provided.

Print name:____________________ Signature: ____________________

Witness:____________________ Date: ____________________

Staff to complete remaining

Eligible for sliding fee discount? Yes ______ No ______ Patient refused __

If yes, acceptable proof of income provided? Yes ______ No ______ Patient refused __

If insured, health insurance card provided? Yes ______ No ______ Not applicable __

Patient reports no income. Yes __________

Patient is unable to obtain proof from an employer. Yes__________
(Includes paid in cash/off-the-books earnings.)

If yes to either question, use the Self-Attestation form.

LISH, Inc. Patient Intake Form

Patient's Demographics:

Primary Facility: ________________________________ **Primary Doctor:** ________________________________
Last Name: ____________________________________ **First Name:** ________________________________
Preferred Name: ________________________________ **Date of Birth:**___/___/_____

Sex: Male / Female Transgender ☐ Preferred Pronoun:______
SSN#:_____-_____-_________ **Primary Language:** ____________________

Race: ***(check all that apply)***
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian
☐ Black or African American
☐ White
☐ Other Race
☐ Other Pacific Islander
☐ Unreported/Refused to Report

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unreported/Refused to Report

ICF? Yes / No
IRA? Yes / No
Day treatment? Yes/ No
Shelter/Public Housing/Homeless? Yes / No
Other:_______________

Mailing Address:____
Apt #:____________**City:**__________________________________**State:**_____________**ZIP:**________________
Physical Address *(if different from mailing):* ____
Apt #:____________**City:**__________________________________**State:**_____________**ZIP:**________________
Home Phone:________________________________ **Cell Phone:** ____
Work Phone:______________________________**Email Address:**____

Relationship Status: (*check one*)
☐ Single
☐ Married
☐ Widowed
☐ Divorced
___Separated
___Partner

Student Status: (*check one*)
___Full Time
___Part Time
___Not a Student

Employment Status: (*check one*)
___Full Time
☐ Part Time ☐
☐ Retired
☐ Active Duty
☐ Self Employed
☐ Unemployed

Employer Name:____
School Name: ____

Parent/Guardian Information:

Parent / Guardian Name:____**DOB:**____/___/_____
Address:____**Phone:** __________________
Parent / Guardian Name:____**DOB:**____/___/_____
Address:____**Phone:**___________________

Emergency Contact:

Name:____ **Relationship to Patient:** ______________________
Address:____ **Phone:** ______________________

Pharmacy Information:

Name:____ **Address:** ______________________________________
City:______________________________**ZIP:**________________ **Phone:**_______________________________

Insurance Information:

Primary Plan Name:_______________________________________**Policy Number:**_____________________________
Primary Care Provider on Insurance Card:____

Secondary Plan Name:_____________________________________**Policy Number:**_____________________________
Primary Care Provider on Insurance Card:____

Responsible Party Information:
Name:____ **Address:**____
City:_________________________________**ZIP:**___________________ **Phone:**______________________________
Relationship to Patient:____

Please indicate how you would like us to contact you:

Would you like access to our patient portal? [ ] Yes [ ] No
Preferred telephone number: [ ] Home [ ] Cell [ ] Work
Is it ok for us to leave a message? [ ] Home [ ] Cell [ ] Work
Best time of day to reach you: [ ] Morning [ ] Afternoon [ ] Evening
Preferred Language: [ ] English [ ] Spanish [ ] Other: __________________

The following questions help LISH, Inc. receive funding so we can make sure that your health care is affordable.

Please check all that apply:

[ ] **Migrant Worker**
Are you currently working in agriculture or farm work? [ ] Yes [ ] No
Was your income mostly the result of farm work last year? [ ] Yes [ ] No
Is your family's income mostly from farm work? [ ] Yes [ ] No
Do you move around in search of farm work? [ ] Yes [ ] No

[ ] **Seasonal Worker**
Will you return to your home state/country after the growing season? [ ] Yes [ ] No

[ ] **Homeless/Living in a Shelter**
Do you live in a shelter or weekly/monthly rental? [ ] Yes [ ] No
Within the last year? [ ] Yes [ ] No
Do you share a single family housing with one or more families? [ ] Yes [ ] No
Or with more than 3 unrelated people? [ ] Yes [ ] No
Within the last year? [ ] Yes [ ] No
Are you currently living with family or friends while looking for housing? [ ] Yes [ ] No

[ ] **Living in Public Housing**
Do you currently live in public housing? [ ] Yes [ ] No
Within the last year? [ ] Yes [ ] No
Do you currently live in senior housing? [ ] Yes [ ] No
Within the last year? [ ] Yes [ ] No
Do you receive Section 8 housing benefits? [ ] Yes [ ] No
Within the last year? [ ] Yes [ ] No

Are you: *(Please check all that apply)*

[ ] **Veteran**
[ ] **LISH, Inc. Employee**
[ ] **LISH, Inc. Board Member**

How did you hear about us? *(Please check one)*

[ ] **Referred by**
[ ] LISH, Inc. Employee [ ] LISH, Inc. Patient [ ] Community agent [ ] Advertisement
[ ] Newspaper [ ] Flyer/Poster [ ] Online [ ] LISH, Inc. Event [ ] Telehealth

LONG ISLAND SELECT HEALTHCARE CONSENT FORM

Consent to Treatment. I authorize Long Island Select Healthcare, Inc. ("LISH, Inc."), and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of LISH, Inc.'s medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by HRH personnel.

Release of Information. I authorize LISH, Inc. to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable LISH, Inc. to obtain payment for the services it provides to me; and (3) to permit LISH, Inc. to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.

I am aware that this authorization to use and disclose information may include information regarding:

- HIV or AIDS
- Alcohol or drug abuse
- Mental illness or any mental health condition
- Sexually transmitted diseases
- Family planning, pregnancy and abortion
- Genetic tests or genetic diseases

I am aware that Long Island Select Healthcare may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

Filming. I understand that photographs or other images of me may be recorded for the LISH's treatment and quality assurance purposes. To the extent that such images identify me, I understand that they shall receive the same confidentiality protections as my other health information. I acknowledge that I strictly prohibited from filming or recording any patients, physicians or staff while at LISH.

Assignment of Benefits. I assign to LISH, Inc. all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by LISH, Inc.

Financial Obligations. I agree, that, except as may be limited by law or LISH, Inc.'s agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at LISH, Inc. facilities in accordance with the rates and terms of HRH in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles.

I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms.

Patient or Responsible Party Signature: ______________________________

Nature of Relationship to Patient (if patient not signing): ______________________________

Date:______________________________

Acknowledgment of Receipt of Notice of Privacy Practices. I acknowledge that I have been provided a copy of the Long Island Select Healthcare (LISH, Inc.) Notice of Privacy Practices, which describes how health information about me may be used and disclosed by LISH, Inc. and how I may obtain access to and control the use and disclosure of this information.

Signature of Patient Date

Reports to NYS Immunization Information System. I hereby authorize LISH, Inc. to report any immunizations that its medical staff administers to me to the New York State Immunization Information System.

Signature of Patient

Please Fill Out the Below if you are Interested in Telemedicine Services (the use of information technology and telecommunication to provide clinical health care remotely):

Virtual Clinic Services requested (check all that apply)

Urgent Medical Services **8 a.m. – 10 p.m.**	☐Assessment, evaluation, diagnosis and treatment for a broad set of complaints
Behavioral Health Services **8 a.m. – 8 p.m.**	☐Psychiatric or Psychological Evaluation Services ☐Psychosocial Evaluation ☐Psychological Testing ☐Neuropsychological Testing ☐Behavioral Health Counseling (short and long term) ☐Medication Management

INFORMED CONSENT: LISH VIRTUAL CLINIC SERVICES

PATIENT NAME	DATE OF BIRTH	DATE OF CONSENT
______________________________	_______________	_______________

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to a patient while the patient is located at another site than the provider.
I, ____________________________, consent to the provision of these services under the following conditions:

- The laws that protect privacy and confidentiality of medical information also apply to telemedicine. Just like any visit to your doctor, telemedicine services are completely confidential and compliant with HIPAA (Health Insurance Portability and Accountability Act) regulations.
- As always, my insurance carrier will have access to my medical records for quality review/audit
- I have the right to withhold or withdraw my consent to the use of telemedicine orally or in writing, in the course of my care at any time, without affecting my right to future care or treatment.

As long as this consent has not been revoked, LISH providers may provide healthcare services to me via telemedicine without the need for me to sign another consent form.

Patient/authorized person's signature*:* ____________________________ Date: __________

If authorized signer, relationship to patient: ____

Witness' signature: ______________________________ Date: ___________

I have been offered a copy of this consent form (please initial): ________________

Client/Patient Photo Release Authorization Form

Purpose of Authorization: By signing this authorization form, I am providing Long Island Select Healthcare, Inc. (LISH) permission to distribute and share my photo. **This is not the photo in your patient chart. This is in case you have your picture taken elsewhere, such as LISH events, patient success stories, and testimonials.** Sharing my photo may include posting the photo on the company website as well as on social media pages and in printed advertisements, promotions and collateral. I agree that I am voluntarily allowing my photo to be used and will receive no financial payment from Long Island Select Healthcare, Inc. for letting them use my photo and allowing them to use my protected health information (photo) for marketing purposes.

Components of my Photo: I understand that the use of my photo may also include the use of my name, location and other information that I provided or authorized to the organization for use along with my photo. I understand that all other protected health information that Long Island Select Healthcare, Inc. creates and maintains for the purpose of my care will not be used in conjunction with my photo or for marketing purposes without prior authorization per privacy regulations of the State and Health Insurance Portability and Accountability Act (HIPAA).

Right to Revoke: I understand that I have the right to revoke this authorization at any time by providing a written request to Long Island Select Healthcare, Inc. I understand that if I choose to revoke this authorization, it will become effective on the day that the authorization was revoked. Any prior uses of my photo along with any protected health information will not be subject to the revocation of authorization. I understand that Long Island Select Healthcare, Inc. will make their best effort to remove my photo from the Long Island Select Healthcare, Inc. website and social media pages.

By signing below, I agree and acknowledge that I have read and understood all the elements of the authorization for use of my photo. I understand that this authorization does not expire, and my photo will only be removed if I revoke this authorization in writing.

Signature:____Date:__________________________________

If not patient, relationship to the patient: ____

Name (print):____Date of Birth: ____________________________

Did You Know?

Community Pharmacies

LISH has partnered with community pharmacies to provide home delivery of your medication. This **free** service is available to you. Tell the pharmacy you are a LISH patient and you would like home delivery of your medications. We will switch your prescriptions for you. The pharmacies you may contact include the following:

Medford Chemist (631) 475 -1171
Centereach Pharmacy (631) 588-8911
Brentwood Pharmacy (631) 273-3314
Chem Rx (516) 536-0800
Community Care Rx (347) 561-3806

Patient Portal

If you sign up for a patient portal you can have access to your results any time, request refills and appointments, and access your medical history. Ask a member from LISH to set you up with a username and password next time you call or visit.

Chronic Care Management (CCM)

If you have **Medicare** and two or more chronic conditions (such as diabetes, asthma, heart disease, etc.), you are eligible for our Chronic Care Management program! At no extra cost to you, you will be assigned a representative from LISH that can help you make appointments, get the refills that you need, and more all over the phone. We understand it can be difficult to keep track of your health care needs on your own and we want to help!

Food Pantry

LISH offers a food pantry on Thursdays at the 159 Carleton Avenue, Central Islip location. Free for all, all are welcome.

Make sure to check out our website and social media pages for updates such as health fair dates, closings due to inclement weather, list of insurances we take, our services, directions, forms and much

more!
www.lishcare.org.