AG WORKER HEALTH & SERVICES

Patient Intake Form

Date:_____

First Name_____ **MI**_____ **Last Name**_____
Date of Birth _____ **Sex**: Male - Female **Preferred Name**: _____

Phone Number: Home/Cell_____ **Email**: _____
May We Leave a Message? Yes No **Do you Prefer to be called or texted?** Call- Text- Both

Physical Address: _____ **Apt/Trailer #**_____**City** _____**State** _____ **Zip Code** _____
Mailing Address: _____**City** _____ **State** _____ **Zip Code** _____

Preferred Language: English - Spanish- Other: _____ **Interpreter Needed?** Yes / No
Are you a veteran? Yes / No **Do you have a disability?** Yes / No

Marital Status: Single - Married - Partner - Widowed - Divorced- Decline to answer

Race: White - More Than One -Asian - Black/African American - Native American - Native Hawaiian or Pacific Islander - Other_____ - Decline to answer
Ethnicity: Hispanic/Latinx - Non Hispanic or Latinx - other_____ - Decline to answer

Emergency Contact: **Name**: _____ **Phone: Home/Cell:** _____
Relationship to you: _____

Your Insurance Name: _____ **Member ID**: _____ **Group ID**: _____

Partner Name- Single **-First Name**_____ **Last Name** _____
DOB_____ **Sex:** M/F **Phone Number**: _____
Race: White - More Than One -Asian - Black/African American - Native American - Native Hawaiian or Pacific Islander - Other_____ - Decline to answer
Ethnicity: Hispanic/Latinx - Non Hispanic or Latinx - other_____ - Decline to answer
Partner's Medical Insurance Name:_____ ID # _____
Partner's Dental Insurance Name:_____ ID# _____

Household Members and Dependents <u>Not Including You or Your Partner</u>: -N/A - : **Total # of Members in Household**:_____

Name: _____ **Sex**: M/F **DOB**: _____ **Relation to you**: _____
Insurance Name:_____ **Insurance ID**: _____

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Name: _____ **Sex**: M/F **DOB**: _____ **Relation to you**: _____
Insurance Name:_____ **Insurance ID**: _____

AG WORKER HEALTH & SERVICES

Patient Intake Form Continued

Employment

Have you or anyone in your household worked in agriculture in the last 24 months or retired from agricultural work? Yes / No
If Yes, who in your household is employed in agricultural work?
Name: _____ **Relationship to you**: _____

What type of Ag Worker? Seasonal Farmworker - Migrant Farmworker (Temporary home) - Retired Farmworker
Type of Work in Agriculture or on Farm?: Crops - Livestock - Nursery - Other: _____
Name of Employer for Agricultural Work:_____ **H2A Visa Worker?** Yes / No
Address: _____ **City**: _____ **State**: _____ **Zip Code**: _____
Dates of Employment: _____ to _____

Current Employment: Full-time - Part-Time - Unemployed - Retired **Are you a Student?** Yes / No
Occupation: _____ **Second Occupation**: N/A _____

Your Current Employer Name: _____ Unemployed-Self-Employed
Address_____**City**_____**State**_____ **Zip Code**_____

Partner's Current Employment: Full-Time - Part-Time- Unemployed - Retired Are you a Student?
Occupation: _____ **Second Occupation**: N/A _____
Employer Name: _____ -Self-Employed
Address_____**City**_____**State**_____ **Zip Code**_____

Estimated Annual Household Income For Previous Year (Including Partner): $ _____ -Unemployed

If you were unemployed last year, what is your estimated income for this year?: $_____
Type of Income Verification Provided? Recent Pay Stubs - 1040 Tax Form - W2 - Employee Letter- Not Provided

By signing this document, you acknowledge that the information above is correct to the best of your knowledge. You also acknowledge that it is your responsibility to notify Ag Worker Health and Services when you have any changes in the information provided above.

_____ _____
Patient or Guardian Signature Date

_____ _____
If signed by legal guardian, please **print** name Relationship to patient

BRIEF EXPLANATION OF AG WORKER HEALTH & SERVICES

Ag Worker Health & Services provides non-emergency health care services to eligible participants and their families. We do not discriminate based on race, color, national origin, sex, age, or disability. English/Spanish bilingual staff and materials are available at our clinics upon request. Charges for clinical services are based on patient income and patients are expected to pay their cost of care, the day of their clinical visit. Inability to pay is not grounds for denial of services.

We will help patients apply for programs that may help to pay their health care services, i.e., Medicaid, Medicare, CHIP, HMK, HMK+, marketplace insurance, etc. If the patient has other sources of payment, such as insurance, we are required to bill the source for reimbursement of services provided. We are known as a "payor of last resort" and cannot pay any portion of insurance co-pays, or serve as a "secondary payor" or "supplement."

We are a "Patient Centered Medical Home" a team of healthcare professionals working together with our patients to improve their health. When possible, patients may select at our clinics a personal clinician or primary care provider they will most often see for their health care needs.

1) Medical, Dental and Behavioral Office Visits:
   - Health history, physical assessment, and necessary follow-up visits will be completed by our staff. This also includes screening for immunization status and life cycle (age) specific screening.
   - We may refer a patient to an off-site provider.

2) Laboratory, X-rays: As ordered by our providers per established protocols.

3) Pharmacy: As ordered by our provider. A pharmacy payment voucher may be issued for the prescription. Over the counter medications (nonprescription drugs) are not covered by a pharmacy voucher. The Program has limitations on prescription refills and/or types of prescription drugs (i.e., nicotine patches, diet pills) that can be filled. Prescriptions are filled with the generic brand whenever possible.

4) Dental: The Program may be able to pay for emergency dental services when there is pain and/or infection (Class I).

5) We cannot pay any hospital charges including Emergency Room, Surgeries, CT Scan, MRI. Please let us know if you have had any of these services.

6) The information you share with us is confidential and will be handled according to current regulations of Privacy and Security (Health Insurance Portability and Accountability Act--HIPAA).

7) Complaints against our services may be mailed to: Compliance Officer, Ag Worker Health & Services, 3318 3rd Ave North Suite 200, Billings MT 59101.Complaint forms are available at any of our clinics or can be mailed upon request. Complainants may speak directly with the Compliance Officer by coming into the Billings address or by calling, 1-800-813-4492.

At any of our locations where you receive care, we will help you organize outside care if needed and may be able to help you pay the off-site provider according to our established protocols.

By my signature below, I have read and understand the services offered by Ag Worker Health & Services. I also understand my financial responsibility for those services not covered by Ag Worker Health & Services.

_____ _____

Client Signature/Firma del Cliente Date/Fecha

DISTRIBUTION: Original/White Copy – Main Office Yellow Copy – Client

Name:_____ **DOB**: _____

AG WORKER HEALTH & SERVICES

Consent Form

Consent to receive Healthcare Services

By signing this document, I hereby consent to receive medical, behavioral health, dental and/or preventive services from Ag Worker Health and Services. This may include, but is not limited to, medical evaluations, diagnostic testing, treatments, counseling, and health education provided by licensed and trained professionals.

Notice of Privacy Practices:

I acknowledge and understand that:

- I have been provided with a copy of Ag Worker Health and Service's Notice of Privacy Practices, which explains how my health information may be used and disclosed.
- Any updates to the Notice of Privacy Practices will be communicated to me promptly.
- All of my healthcare information will be kept private and secure under the federal law of HIPPA.

Verbal Communication Authorization: Would you like to allow anyone else to communicate with Ag Worker Health & Services about your healthcare? No - Yes

Name: _____ Relation to you: _____ Phone: _____

Name: _____ Relation to you: _____ Phone: _____

Financial Responsibility:

I acknowledge and understand that:

- I am responsible for any fees or charges associated with my care, including those not covered by insurance.
- I understand that my bill I will receive is based on Ag Worker Health & Service's sliding fee scale.
- It is my responsibility to inform the clinic of any changes to my insurance or financial situation.
- Although I may potentially qualify for vouchers or financial assistance with specific healthcare services, Ag Worker Health & Services does not guarantee they will be able to pay for any costs incurred for services received outside of the clinic, including but not limited to; specialist consultations, laboratory tests, advanced imaging (CT Scans, MRIs), Emergency Room visit, or other hospital services.

Consent for Communication: I consent to:

- Being contacted via phone, mail, email, or text for appointment reminders, test results, and clinic updates.

I prefer <u>not</u> to be contacted via: (circle one or more) phone call - mail - email - text

Telehealth Consent:

By signing this document, you consent to:

- Receive telehealth services. Telehealth involves the use of electronic communication to deliver healthcare services, including but not limited to video calls, phone consultations, and other forms of digital communication. I understand that there are potential risks such as technology failures, security breaches, or delays in care. Although efforts are made to protect your privacy and confidentiality, no system is entirely secure. **To Decline Telehealth Services, initial here _____**

Brief Explanation of Services: I acknowledge that:

- I have been provided with a copy of Ag Worker Health & Service's Brief Explanation of Services

I hereby certify that the information given on this patient intake form is true and accurate to the best of my knowledge. I understand that it is in my best interest to report all changes in a timely manner. I consent, acknowledge, and authorize that I have read and understand all information on this form and the forms provided such as Notice of Privacy Practices and Brief Explanation of Services.

_____ _____

Patient or Legal Guardian Signature | Date

_____ _____

If signed by legal guardian, please **<u>print</u>** name | Relationship to Patient

_____

Dependents/Children

PRAPARE Smart Form in eCW

Money and Resources

What is your current housing situation?

- ☐ I have housing
- ☐ I do not have housing
- ☐ I choose not to answer this question

Are you worried about losing your housing?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

What is the highest level of school that you have finished?

- ☐ Less than a high school degree
- ☐ High school diploma or GED
- ☐ More than high school
- ☐ I choose not to answer this question

What is your current work situation?

- ☐ Unemployed and seeking work
- ☐ Part time or temporary work
- ☐ Full time work
- ☐ Otherwise unemployed by not seeking work (e.g. retired, student, disabled, unpaid caregiver)
- ☐ I choose not to answer this question

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply;

- ☐ Food
- ☐ Clothing
- ☐ Utilities
- ☐ Child Care
- ☐ Medicine or any health care (medical, dental, mental health or vision)
- ☐ Phone
- ☐ Other (please write in notes)
- ☐ I do not have problems meeting my needs
- ☐ I choose not to answer this question

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

- ☐ Yes, it has kept me from medical appointments or from getting my medications
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living
- ☐ No
- ☐ I choose not to answer this question

Social Emotional Health

How often do you see or talk to people that you care about and feel close to? (e.g. talking to friends on the phone, visiting friends or family, going to church or club meetings).

- ☐ Less than once a week
- ☐ 1 or 2 times a week
- ☐ 3 to 5 times a week
- ☐ More than 5 times a week
- ☐ I choose not to answer this question

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled.

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much
- ☐ I choose not to answer this question

Additional Questions

In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correction facility?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

Are you a refugee?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

What Country are you from?

- ☐ United States
- ☐ Country other than United States: Please specify _____
- ☐ I choose not to answer this question

Do you feel physically and emotionally safe where you currently live?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I choose not to answer this question

In the past year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I have not had a partner in the past year
- ☐ I choose not to answer this question

MHJP Legal Screening Tool

Name: _____ _____ _____
First Middle Last

Address: _____
Street Apt/Unit# City State Zip

Phone: (_____) _____-_____ **Safe to leave voicemail?** □ Yes □ No

Birth Date: (mm/dd/yy) ___/___/_____ **SSN**: XXX-XX-__ __ __ __

Gender: □ Female □ Male □ Prefer not to answer **Today's Date**: ____/_____/_____

In the past year, have you or any family members you live with had an issue? Check all that apply.

□ housing	(rental or homeownership issues)	□ employment	(wages, discrimination, termination, unemployment)
□ family law	(divorce, parenting, support)	□ taxes	(federal or state tax disputes, tax identification numbers)
□ benefits	(Social Security, TANF, SNAP, Medicaid)	□ immigration	(Green card renewals, Citizenship petitions)
□ consumer	(debt collection, bankruptcy, loan issues)	□ other	(*please describe:* _____

Do you currently have a problem with your housing? (e.g. pests, mold, lead, having utilities shut off, landlord disputes)	□ Yes □ No □ I choose not to answer
Are you worried about losing your housing?	□ Yes □ No
Do you need advice or assistance in filing for or answering a dissolution (divorce) petition?	□ Yes □ No □ I choose not to answer
Are you having a child custody issue or dispute?	□ Yes □ No □ I choose not to answer
Have you received a notification from the State of Montana denying, reducing, or terminating your Medicaid, Food Stamps (SNAP) or TANF benefits?	□ Yes □ No □ I choose not to answer
Are your wages being garnished or are you being harassed by collection companies?	□ Yes □ No □ I choose not to answer
Do you need to write a will or to name someone to make medical or financial decisions for you if you are unable to do so?	□ Yes □ No □ I choose not to answer
Are your children able to get the services they need from their school?	□ Yes □ No □ I choose not to answer
Do you feel physically and emotionally safe where you currently live?	□ Yes □ No □ I choose not to answer
In the past year, have you been afraid of your partner or ex-partner?	□ Yes □ No □ I choose not to answer
Have you applied for and been denied unemployment, workers comp, or disability benefits?	□ Yes □ No □ I choose not to answer
Are you having any federal tax problems and/or have you received any notices from the IRS?	□ Yes □ No □ I choose not to answer
Would you like to speak with a legal advocate about these or other civil legal issues, at no cost to you?	□ Yes □ No □ I choose not to answer