COMMUNITY HEALTH SERVICE INC

Registration form

HOH ID: _____

At Community Health Service Inc. (CHSI), patients are never turned away due to an inability to pay. CHSI offers a discount on your services based on your annual income and household size. Please complete the application below and provide documentation to verify your income. Your application will not be processed until income verification is received. However, CHSI will retroactively discount charges if an application is submitted within 30 days of the date of service.

Head of Household (Guarantor) Information:

Name: (First, MI, Last)		Date of Birth (DOB):	SSN:
Mailing Address:		Primary Phone #: ☐ Cell ☐ Home ☐ Other	Secondary Phone #: ☐ Cell ☐ Home ☐ Other
City/State/ZIP			
Emergency Contact Name:		Phone Number:	Relationship to You:
Email Address (used for Patient Portal and E-statements:			Insurance ☐ Yes ☐ No

Household Information: List all individuals you support that will be seen at CHSI.

Name (First, MI, Last)	DOB	Relationship to Guarantor	Income	Insurance	SSN:
1.			**YES / NO**	**YES / NO**	
2.			**YES / NO**	**YES / NO**	
3.			**YES / NO**	**YES / NO**	
4.			**YES / NO**	**YES / NO**	
5.			**YES / NO**	**YES / NO**	

Total # of people you support, including yourself: _____

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Household Information: List all individuals you support that will be seen at CHSI.

Name (First, MI, Last)	DOB	Relationship to Guarantor	Insurance	SSN:
6.			**YES / NO**	
7.			**YES / NO**	
8.			**YES / NO**	
9.			**YES / NO**	
10.			**YES / NO**	
11.			**YES / NO**	
12.			**YES / NO**	
13.			**YES / NO**	
14.			**YES / NO**	
15.			**YES / NO**	
16.			**YES / NO**	
17.			**YES / NO**	
18.			**YES / NO**	
19.			**YES / NO**	
20.			**YES / NO**	