Healthways / Regional Medical Center at Lubec, Inc.

Registration Questionnaire

RMCL is a Federally Qualified Health Center, partially funded by the Federal Bureau of Primary Health Care.
As a requirement for funding, we are responsible for collecting the following data on ALL of our patients:

Disclaimer - No patient specific information is reported. Only Group totals are reported to required agencies.

Race, Please Choose all that apply White _____ Black / African American _____ Asian _____ American / Alaskan Native _____

Native Hawaiian _____ Other Pacific Islander _____ Unknown / Refuse to report _____

Veteran Y / N Migrant Worker Y / N Primary Language English? Y / N Ethnicity Hispanic or Latino Y / N

Have you been homeless at any point during the calendar year? Y / N If yes please select one of the following living arrangements:

Homeless Shelter_____ Street_____ Transitional_____ Doubling Up_____

With which gender do you identify Male _____ Female _____ Other _____

Transgender Female to Male _____ Transgender Male to Female _____ Choose not to disclose _____

Sexual Orientation Straight _____ Lesbian / Gay _____ Bi-Sexual _____

Something else _____ Don't know _____ Chose not to disclose _____

MEDICARE QUESTIONNAIRE - This section is intended for prescreening purposes only.

Are you receiving Black Lung Benefits?	Y / N
Are services to be paid by a government program (i.e., research grant)?	Y / N
Has the Department of Veteran's Affairs authorized care at this facility?	Y / N
Is your illness or injury due to a work-related accident or condition?	Y / N
Is your illness or injury due to a non-work related accident or condition?	Y / N
Do you receive group medical coverage based on you or your spouse's current employment? (Note: This does not include retirement benefits that are secondary to Medicare)	Y / N

Are you entitled to Medicare based on: Age____ Disability _____ End Stage Renal Disease (ESRD) _____

Estimated annual income by family size (please circle)

family size	Category A	Category B	Category C	Category D	Category E
1 Yearly	$12,760 or Less	$12,761 - $15,950	$15,951 - $19,140	$19,141 - $25,520	$25,521 or more
2 Yearly	$17,240 or Less	$17,241 - $21,550	$21,551 - $25,860	$25,861 - $34,480	$34,481 or more
3 Yearly	$21,720 or Less	$21,721 - $27,150	$27,151 - $32,580	$32,581 - $43,440	$43,441 or more
4 Yearly	$26,200 or Less	$26,201 - $32,750	$32,751 - $39,300	$39,301 - $52,400	$52,401 or more
5 Yearly	$30,680 or Less	$30,681 - $38,350	$38,351 - $46,020	$46,021 - $61,360	$61,361 or more
6 Yearly	$35,160 or Less	$35,161 - $43,950	$43,951 - $52,740	$52,741 - $70,320	$70,321 or more
7 Yearly	$39,640 or Less	$39,641 - $49,550	$49,551 - $59,460	$59,461 - $79,280	$79,281 or more
8 Yearly	$44,120 or Less	$44,121 - $55,150	$55,151 - $66,180	$66,181 - $88,240	$88,241 or more
add per additional member	$4,480	$5,600	$6,720	$8,960	N/A

I verify that the information listed above is correct to the best of my knowledge.

Name:_____ DATE:_____

( ) Patient ( ) Parent ( ) Guardian

Revised 2/26/20