Family Registration Form

Return Address
KSFHP – **Pat Fernandez** **Cell:** (620) 617-7428
2501 Market Place, Ste D **Fax:** (785) 827-1544
Salina, KS 67401

Primary Farmworker (Head of Household) Information

Today's Date: _____

First Name	*Middle*	*Last Name*	*Other Names*

Home Address	*City*	*State*	*Zip*
Mailing Address (if different)	*City*	*State*	*Zip*

Home Phone	*Cell Phone*	*Email*

How would you like to receive information? text? ☐ Yes ☐ No email? ☐ Yes ☐ No *In what language?*

Emergency Contact Name	*Emergency Phone*	*What language do you speak in your home?*

Housing Type ☐ own ☐ public housing ☐ rent ☐ shelter ☐ transitional ☐ doubling up ☐ street ☐ other

Employment Information

Agriculture Person Employed	*Agriculture Employer Name*

Employer's Address	Income Type ☐ wages ☐ self-employed ☐ retirement ☐ other

City	*State*	*Telephone*

Amount	Frequency ☐ weekly ☐ every 2 weeks ☐ monthly ☐ yearly	*Start date*	*End date*

Agricultural Worker Designation & Questionnaire

People who have been employed in agriculture may qualify for health services. Please answer the following questions.

1. In the last 2 years, have you or anyone in your family, worked in any type of agriculture (farm work) like: planting, picking, preparing the soil, packing house, driving a truck for any type of farm work, worked with animals like cows, chickens, etc?
   ☐ **Yes** ☐ **No**
2. In the last 2 years, have you or a member of your family lived away from home in order to work in any type of agriculture (farm work)?
   ☐ **Yes** ☐ **No**
3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age (too old to do the work)?
   ☐ **Yes** ☐ **No**
4. Are you exposed to chemicals, fumes, dusts, noise, and/or high heat at your work or away from work?
   ☐ **Yes** ☐ **No**
   a. If yes, do you think these are harming you?
   ☐ **Yes** ☐ **No**
5. Can we share your family information with the Kansas Migrant Education Program and/or Harvest America Corporation?
   ☐ **Yes** ☐ **No**

Person Employed	*Employer Name*			
Employer's Address	*City*	*State*	*Telephone*	Income Type
				☐ wages ☐ self-employed ☐ retirement ☐ other
Amount	Frequency ☐ weekly ☐ every 2 weeks ☐ monthly ☐ yearly	*Start date*	*End date*	

For office use only. Registration Type:
☐ KSFHP ☐ TB Program Only
Approved by:
_____
Date: _____

Household Information

Your income and family size help us decide if you qualify for services. Complete the questions below for each person in your family. Start with yourself! If you have more than 6 people in your family, please attach another sheet of paper.

	Person 1 (Yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
First Name						
Middle Name						
Last Name						
Other Names						
What is this person's relationship to you?	*self*					
Do they live with you?		☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Date of Birth (mm/dd/yyyy)						
Gender	☐ male ☐ female	☐ male ☐ female	☐ male ☐ female	☐ male ☐ female	☐ male ☐ female	☐ male ☐ female
Marital Status	☐ partnered ☐ married ☐ single ☐ divorced ☐ widowed ☐ separated	☐ partnered ☐ married ☐ single ☐ divorced ☐ widowed ☐ separated	☐ partnered ☐ married ☐ single ☐ divorced ☐ widowed ☐ separated	☐ partnered ☐ married ☐ single ☐ divorced ☐ widowed ☐ separated	☐ partnered ☐ married ☐ single ☐ divorced ☐ widowed ☐ separated	☐ partnered ☐ married ☐ single ☐ divorced ☐ widowed ☐ separated
Race (select all that apply)	☐ White ☐ Black/African American ☐ American Indian/Alaska native ☐ Asian ☐ Pacific islander ☐ Native Hawaiian ☐ choose not to disclose	☐ White ☐ Black/African American ☐ American Indian/Alaska native ☐ Asian ☐ Pacific islander ☐ Native Hawaiian ☐ choose not to disclose	☐ White ☐ Black/African American ☐ American Indian/Alaska native ☐ Asian ☐ Pacific islander ☐ Native Hawaiian ☐ choose not to disclose	☐ White ☐ Black/African American ☐ American Indian/Alaska native ☐ Asian ☐ Pacific islander ☐ Native Hawaiian ☐ choose not to disclose	☐ White ☐ Black/African American ☐ American Indian/Alaska native ☐ Asian ☐ Pacific islander ☐ Native Hawaiian ☐ choose not to disclose	☐ White ☐ Black/African American ☐ American Indian/Alaska native ☐ Asian ☐ Pacific islander ☐ Native Hawaiian ☐ choose not to disclose
Latino	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Gender Identity	☐ male ☐ female ☐ transgender male ☐ transgender female ☐ genderqueer ☐ other ☐ choose not to disclose	☐ male ☐ female ☐ transgender male ☐ transgender female ☐ genderqueer ☐ other ☐ choose not to disclose	☐ male ☐ female ☐ transgender male ☐ transgender female ☐ genderqueer ☐ other ☐ choose not to disclose	☐ male ☐ female ☐ transgender male ☐ transgender female ☐ genderqueer ☐ other ☐ choose not to disclose	☐ male ☐ female ☐ transgender male ☐ transgender female ☐ genderqueer ☐ other ☐ choose not to disclose	☐ male ☐ female ☐ transgender male ☐ transgender female ☐ genderqueer ☐ other ☐ choose not to disclose

	Person 1 (Yourself)	Person 2	Person 3	Person 4	Person 5	Person 6
Sexual Orientation	☐ heterosexual ☐ homosexual ☐ bisexual ☐ something else ☐ don’t know ☐ choose not to disclose	☐ heterosexual ☐ homosexual ☐ bisexual ☐ something else ☐ don’t know ☐ choose not to disclose	☐ heterosexual ☐ homosexual ☐ bisexual ☐ something else ☐ don’t know ☐ choose not to disclose	☐ heterosexual ☐ homosexual ☐ bisexual ☐ something else ☐ don’t know ☐ choose not to disclose	☐ heterosexual ☐ homosexual ☐ bisexual ☐ something else ☐ don’t know ☐ choose not to disclose	☐ heterosexual ☐ homosexual ☐ bisexual ☐ something else ☐ don’t know ☐ choose not to disclose
Preferred Language						
Fluent in English	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Veteran	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Smoking Status	☐ current smoker ☐ former smoker ☐ never smoker	☐ current smoker ☐ former smoker ☐ never smoker	☐ current smoker ☐ former smoker ☐ never smoker	☐ current smoker ☐ former smoker ☐ never smoker	☐ current smoker ☐ former smoker ☐ never smoker	☐ current smoker ☐ former smoker ☐ never smoker
Pregnant?	☐ yes, due date: ☐ no	☐ yes, due date: ☐ no	☐ yes, due date: ☐ no	☐ yes, due date: ☐ no	☐ yes, due date: ☐ no	☐ yes, due date: ☐ no
Type of Health Care Coverage	☐ none ☐ KanCare (Title 19) ID# ____________. ☐ KanCare (Title 21) ID# ____________. ☐ Medicare ☐ private/employer insurance ☐ other	☐ none ☐ KanCare (Title 19) ID# ____________. ☐ KanCare (Title 21) ID# ____________. ☐ Medicare ☐ private/employer insurance ☐ other	☐ none ☐ KanCare (Title 19) ID# ____________. ☐ KanCare (Title 21) ID# ____________. ☐ Medicare ☐ private/employer insurance ☐ other	☐ none ☐ KanCare (Title 19) ID# ____________. ☐ KanCare (Title 21) ID# ____________. ☐ Medicare ☐ private/employer insurance ☐ other	☐ none ☐ KanCare (Title 19) ID# ____________. ☐ KanCare (Title 21) ID# ____________. ☐ Medicare ☐ private/employer insurance ☐ other	☐ none ☐ KanCare (Title 19) ID# ____________. ☐ KanCare (Title 21) ID# ____________. ☐ Medicare ☐ private/employer insurance ☐ other
IMPORTANT! Answer for persons age 12 and older: Over the last 2 weeks, how often have you been bothered by the following problems?						
1. Little interest or pleasure in doing things	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day
2. Feeling down, depressed, or hopeless	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day	☐ 0 not at all ☐ 1 several days ☐ 2 more than half the days ☐ 3 nearly every day

Certification I certify that the information above is accurate to the best of my knowledge. **Signature** ______________________________ **Date** ____________

Authorization for Release of Information

I authorize Kansas Statewide Farmworker Health Program to use and disclose any information acquired during the course of my registration, examination and treatment (including protected health information) for the purpose of medical treatment or consultation, billing or claim payments and care coordination for myself and my listed dependents above.

Signature ______________________________ **Date** ____________ **Signature** ______________________________ **Date** ____________

KSFHP Client Rights and Responsibilities

KSFHP strives to provide comprehensive and preventive health care to farmworkers and their dependents. In order to maintain optimum communication, closer patient/provider relationships, and efficient care, KSFHP presents the following Rights and Responsibilities for you and your family. The Program's Website address is www.ksfhp.org.

Client Rights

I have the right:

- To be treated with respect and have my concerns acknowledged.
- To expect personal information and information about my health treated confidentiality by KSFHP staff and providers.
- To be assigned a provider who is in charge of my care if I have multiple health problems or am seeing specialists or hospitalized.
- I have a right to have a family member or friend by with me to speak up for me and help get things done.
- To be informed of tests, treatments, including prescriptions and how that will help my health. Regional case managers and health promoters can facilitate communication with providers.
- To receive in understandable language adequate information from my provider concerning my diagnosis and its related treatment. Regional case managers and health promoters can facilitate communication with providers.
- Be told of all my options to allow me to make my own personal decisions regarding my health care. Regional case managers and health promoters can facilitate communication with providers.
- Be told about policies and procedures, fees and charges for services made by the provider and to receive an explanation about my service charges and co-pays.
- When referrals are made to other agencies, I should receive an explanation of my responsibilities.
- Not to be discriminated against because of race, religion, national origin, language, sex or age.
- To be heard if I have suggestions or complaints. I understand that I may contact my regional case manager or the KSFHP Director, Cynthia Snyder, at Cynthia.Snyder@ks.gov, (785) 296-8113 to communicate suggestions or complaints.

Client Responsibilities

I have a responsibility:

- To provide the following information:
  - Basic information to KSFHP staff to determine eligibility for KSFHP.
  - Updated information to my KSFHP case manager and providers when there are any changes in address, household information, and financial status or if leaving the area. I understand that if I provide false information I may be made ineligible for the program either temporarily or permanently.
  - Information about my health to KSFHP providers, including any past or present abuse of pain medication.
- To make and keep scheduled appointments and arrive on time. Should an emergency occur I will contact the provider to cancel and if possible reschedule.
- In cases where insured, to assure that Medicaid coverage or other insurance is up to date and active, and that insurance cards are brought to appointments.
- If uninsured, to take a KSFHP voucher to all appointments (arrange for vouchers ahead of schedule unless on weekend hours or in cases of same day appointments).
- I understand if I miss two scheduled appointments within six months I may be suspended from voucher covered services for the upcoming six months.
- To cooperate with all health and KSFHP personnel and to ask questions if I do not understand.
- To treat all KSFHP providers and staff with respect and I understand that complaints about disrespectful behavior will be taken seriously.
- To pay all established co-pays or payments including the following:
  - The co-pays for my primary care provider and specialist care.
  - Co-pays and any amount over the $300 total per year for dental services.
  - The first $5 of each prescription and anything over the $50 covered by the KSFHP voucher for pharmacy. I will pay for all prescriptions when I reach my yearly limit.
  - Any service costing over $150 without prior authorization.
  - Payments for services NOT covered by KSFHP.
- I understand that I have ultimate responsibility for paying bills.
- To contact assigned my regional case manager before changing my primary care, medical or dental providers. I agree not seek care with multiple providers (not including specialty care) without consultation with my regional case manager.
- Ultimately, I understand that my health is my own responsibility and that I should be proactive with regards to my needs.