CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM
2017 ELIGIBILITY / REGISTRATION FORM

[ ] HOH / MSAW [ ] Dependent / Spouse [ ] Dependent / Child [ ] Dependent / Other, specify: _____

Please see the reverse side for instructions on how to complete the 2017 Eligibility/Registration Form.

Patient's Name: _____ (First) _____ (Middle) _____ (First last name) _____ (Second last name)

Date of Birth [MM/DD/YYYY]: _____/_____/_____ Phone: _____

Gender Identity: [ ] Male [ ] Female [ ] Transgender [ ] Other, specify: _____ [ ] Declined to answer

Address: _____ Town: _____ State: _____ Zip: _____

If the patient is a dependent, provide the **name of the migratory / seasonal agricultural worker head of household (HOH)**.

HOH Name: _____ Date of Birth [MM/DD/YYYY]: _____/_____/_____

Have you registered in the CRVFHP in the past? [ ] Yes [ ] No

SECTION I: IF PATIENT IS A DEPENDENT, ONLY ANSWER 1A, 1B & 2, OTHERWISE FULLY COMPLETE 1-3

1A. Within the past 24 months have you or a member of your family worked in agriculture/farming, as your/their principal employment? [ ] Yes [ ] No

1B. Have you or a member of your family stopped migrating to work in agriculture because of a disability or old age? [ ] Yes [ ] No

2. In the past 24 months, have you or a member of your family moved here from outside the Valley to seek employment in agriculture? **If yes**, where did you move from? _____ [ ] Yes [ ] No

3. Employer: What is the name of the farm where you now work or where you last worked? _____

Where is that farm located? Town: _____ State: _____

SECTION II: TO BE COMPLETED FOR ALL PATIENTS

4. Race: [ ] Black/African American including Hispanic/Latino Descent [ ] White including Hispanic/Latino Descent [ ] American Indian/Alaska Native including Hispanic/Latino Descent
[ ] Asian [ ] Native Hawaiian [ ] Other Pacific Islander
[ ] More than one race [ ] Unreported / Refused to report

5. Country of Origin: [ ] El Salvador [ ] Guatemala [ ] Jamaica
[ ] Mexico [ ] Puerto Rico [ ] Other, specify: _____

6. Hispanic/Latino: [ ] Yes [ ] No

7. Language: Best served in a language other than English? [ ] Yes [ ] No Do you need an interpreter? [ ] Yes [ ] No
If you need an interpreter, in what language? _____

8. Housing: [ ] Own [ ] Rent [ ] Shelter [ ] Transitional [ ] Doubling Up [ ] Street [ ] Unknown [ ] Other: _____

9. Health Insurance: [ ] None [ ] Other, specify: _____

10. Smoking Status: [ ] Current every day smoker [ ] Current someday smoker [ ] Former smoker [ ] Never smoker
[ ] Smoker, current status unknown [ ] Unknown if ever smoked

11. Veteran: [ ] Yes [ ] No

12. H2A Worker: [ ] Yes [ ] No

13. Sexual Orientation: [ ] Straight (not lesbian or gay) [ ] Lesbian or gay [ ] Bisexual
[ ] Something else [ ] Don't know [ ] Declined to answer

SECTION III: ENTER ALL INCOME SOURCES; HOH INCOME INFORMATION SHOULD BE INPUT FOR DEPENDENTS

14. Income: Farm Income: _____ X _____ + Other Income: _____ = _____
(wkly/monthly pay rate X # of wks/months in Valley + other sources of income/benefits = annualized family income)

Type of other employment/sources of other income (including those of dependents): _____
(list other source(s) of income for verification)

15. # of Dependents: in the Valley: _____ + outside the Valley: _____ = Total: _____

ACKNOWLEDGEMENT: I understand that I may be asked to pay a co-payment for each visit. Co-pay amounts may vary depending on the service, equipment or supplies provided. I have been informed that services will not be denied because of inability to pay.

AUTHORIZATION: I hereby authorize disclosure of Protected Health Information (PHI) and the subsequent release of records to the Massachusetts League of Community Health Centers, CRVFHP, its funding source, and to the referred / referring Health Provider; the purpose of this authorization is to support and document medical care and / or process payments to migratory and seasonal agricultural workers and their families which are supported directly and indirectly through CRVFHP Voucher and / or Outreach funds in 2017.

_____ _____
Patient Signature **Parent / Guardian (if patient is less than 18 years old)**

The CRVFHP reserves the right to verify the information provided above.

Interviewer Signature: _____ Telephone: (_____) _____

Agency / Provider: _____ Date of Application: _____/_____/_____

White Copy – CRVFHP (mail) **Yellow Copy – Agency / Provider** **Pink Copy – Outreach**

CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM
2017 ELIGIBILITY / REGISTRATION FORM

Program Eligibility Requirements

Migratory and seasonal agricultural workers (MSAWs) and their families are eligible for services through the CRVFHP while present in the Connecticut River Valley.

A migratory agricultural worker is an individual whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who establishes a temporary home for the purposes of such employment. This includes anyone who has been employed as a migratory agricultural worker within the last 24 months as their primary income.

If a former migratory worker stopped working due to disability or old age the worker and his/her dependent family members are considered migratory workers for life and still eligible for the CRVFHP.

A seasonal agricultural worker is an individual whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who does not establish a temporary home for the purposes of employment. This includes anyone who has been employed as a seasonal agricultural worker within the last 24 months as their primary income.

A person who worked as a migratory agricultural worker but is now working as a construction worker, meat packer, landscaper, etc. is eligible for the CRVFHP for 24 months after stopping farm work. Individuals eligible for services through the CRVFHP are those individuals working in:

- Preparing, irrigating or spraying the fields, nurseries, orchards
- Planting, picking, sorting, packing, or transporting fruits, vegetables, grains, nuts, tobacco, grass, hay or other agricultural products
- Planting trees; working with Christmas trees; picking pine needles or Spanish moss
- Taking care of fish, chickens, ducks, turkeys, cows, goats, sheep, fish, clams, etc.

Persons not eligible include:

- Farm crew leaders who do not work in the fields for wages
- Individuals coming to the Connecticut River Valley for purposes other than agricultural work who have not done agricultural work in the last 24 months

Instructions for completing the Eligibility / Registration Form (reverse side)

1. This Eligibility / Registration Form **must be completed once per calendar year for each patient**. All dependent family members of MSAWs are eligible for primary care services through the CRVFHP, however, an Eligibility / Registration Form must be completed for the HOH first. Please check the appropriate box (HOH or dependent) at the top of form.
2. Print the patient's **complete name,** including all hyphenated or multiple last names.
3. Enter the patient's date of birth in MM / DD / YY (month / date / year) format.
4. Check the patient's current gender identity. Please check all that apply.
5. Enter the patient's phone number used while in the Valley. Also, list the complete address in the Valley – street, town, state, zip.
6. If the patient is a dependent of a MSAW, record the head of household (HOH) name and HOH date of birth.
7. If the patient has registered for the CRVFHP at any point in the past, please answer "yes." If this is the first time the patient has ever enrolled in the CRVFHP, answer "no."
8. Section I: Answer Questions 1A, 1B, 2 and 3 based on the HOH. REMINDER: Questions 1A, 1B, and 2 must be answered for all patients; Question 3 only needs to be answered for the HOH.
   - **To be eligible for CRVFHP services, applicants MUST respond "yes" to Question 1A or 1B or 2.**
9. Section II: If the patient is eligible, record answers to all questions in Section II (Questions 4-13).
   - For Question 8, if the patient is a dependent, the answer should match that of the HOH.
   - For Question 11, veteran status is defined as an individual who has completed service in the Uniformed Services of the United States.
10. Section III: If the patient is eligible, record answers to all questions in Section III (Questions 14 & 15).
    - For Question 13, ask the patient how they think of themselves and check the appropriate sexual identity.
    - **For Question 14, expected annual income MUST be calculated for the entire family in order to determine income as a percent of the current federal poverty level. Include expected income from non-agricultural sources under "Other Income." Also include expected income of other dependent family members in the same household. If the patient is a dependent and does not receive their own income, record the income of the HOH. REMINDER: This should reflect the total YEARLY income for all those who receive income in the household.**
11. Have the patient or parent / guardian sign the completed application. If the patient or parent / guardian is unavailable to sign and the interviewer has obtained the information necessary to answer all the Questions, the interviewer's signature and the information supplied will be sufficient to determine eligibility.
12. Interviewer must sign the application in the space indicated for "Interviewer Signature" and provide their telephone number, Agency/Provider name and record the date the application was completed (this date serves as the registration date).
13. Interviewer retains yellow copy for Agency / Provider and pink copy for Outreach. Please return completed Eligibility / Registration Form (white copy) via encrypted email or mail to:

    Massachusetts League of Community Health Centers
    Attention: CRVFHP
    40 Court Street, 10th Floor
    Boston, MA 02108

    - **Please do not submit incomplete forms or complete forms that indicate a patient is not eligible for CRVFHP services. They will be returned unprocessed.**
    - **ALL PATIENT-IDENTIFIABLE DOCUMENTATION MAILED TO THE CRVFHP MUST BE MARKED "CONFIDENTIAL."**
14. **This application remains valid through December 31, 2017.**

White Copy – CRVFHP (mail) **Yellow Copy – Agency / Provider** **Pink Copy – Outreach**