



Revised June 2020

INSTRUCTIONS & REQUIREMENTS FOR BECOMING A PATIENT

1. You must be an Iredell County resident who is at least 18 years old.
2. You cannot have health insurance, Medicaid or Medicare.
3. You must fill in all sections of the application packet and return the **completed** forms with **PROOF OF INCOME**.
4. You must present a valid picture ID.
5. We reserve the right to determine who will be eligible to become a patient. We also reserve the right to discharge patients who do not honor their appointments and/or comply with clinic policies.
Common reasons for patient dismissal:
 - a. **Failure to show up for scheduled appointments.** We require that patients call 24 hours prior to their appointment to cancel or reschedule.
 - b. Seeking narcotic drugs
 - c. Providing false information of **any kind** will be grounds for immediate dismissal
6. Eligibility **does not** include family members and is **only** extended to the person who has completed the application.

This clinic is a medical nonprofit organization run predominantly by volunteers. HealthReach Community Clinic relies on donations from citizens of the community, local organizations and grants in order to serve our patients. We are not affiliated with any hospital or government agency. Our services are limited to basic health care and does not include dental care.

HealthReach Community Clinic will do whatever we can to help, BUT potential patients are not guaranteed or entitled to specific services.

I understand the contents of this document and agree to comply with the Clinic's policies. I also acknowledge that all the information I supply is true. I understand that HealthReach Clinic operates on a limited availability basis. It is not possible for the volunteer providers or staff to be available 24 hours a day, seven days a week.

Should I ever need emergency medical care, I will dial 911 or go to the nearest emergency room. If I need non-emergency care when the clinic is closed, I will seek other options such as the urgent care center.

Print Applicant's Name _____ Date _____

Applicant's signature _____ Date _____
Patient/Authorized representative*

*If Authorized Representative, please indicate relationship to patient:

____ Spouse ____ Parent ____ Other (Please specify) _____



HEALTHREACH
Community Clinic

Applicant

Name: _____ Date: _____

(Please Print)

For New Patients and Existing Patients being recertified:

Please be sure to include the following information with your application. Bring originals of each document. Failure to bring documentation will delay the application process and treatment.

- Picture identification
- Copy of Current Federal Tax Return including all Schedules. If you did NOT file taxes last year, please sign and date the 4506T form. If you are married, your spouse must also provide a Federal Tax Return or sign your 4506T form if your spouse did not file taxes.
- Proof of residency (piece of current mail with your name and address)
- Completed NC MedAssist Application

Proof of income for **EVERY** member of household. Proof of income includes:

- If working a job:
 - Last 4 pay stubs (consecutive)
 - OR, a letter from your employer on company letterhead listing your pay rate & date
 - A form is available at the front desk – Please ask if needed
- For Self-Employment income, please provide complete bank statements for the last 3 consecutive month(s) and provide last year's tax return and **All Schedules**.
- Food Stamps (copy of award letter)
- Child Support Payments (copy of decree)
- Social Security Income (copy of current year Notice of Award); 1099 is NOT accepted
 - Please circle what type of SS you are receiving:

Retirement Disability Dependents Benefits Survivors Benefits

- Retirement/Pension Income (copy of the most recent check stub from where payment was received)
 - Unemployment Benefits (copy of awards letter or printout of weekly payment)
 - Workman's Compensation Benefits awards letter
 - Housing Assistance Letter
- **If you have no income**, you must complete the **Statement of No Income**. Also, the person(s) who supports you must complete and sign the **Support Letter** (see page 4) OR provide a letter from FeedNC (formerly Mooresville Soup Kitchen), Christian Mission, or 5th Street Ministries.

Please bring your completed paperwork to HealthReach Monday through Thursday OR mail all materials to HealthReach at 400 E. Statesville Ave., Suite 300, Mooresville, NC 28115. It may take up to 2 weeks to process your paperwork. After it is determined that you qualify, you will be called and an appointment can be scheduled.

NOTE: We do NOT prescribe or keep on our premises narcotics or controlled substances.



Patient Eligibility Screening Form

List All People (Including Yourself) Living Full Time at This Same Street Address

Name	Age	Relationship	Income/Month
1.			\$
2.			\$
3.			\$
4.			\$
5.			\$
6.			\$
7.			\$

Add more names and information at the bottom of this page if needed

Client Statement and Release of Information

I do hereby certify that the information above is truthful and accurate to the best of my knowledge and ability. I understand that if I intentionally fail to disclose true and accurate information that services can be suspended or terminated as deemed appropriate by HealthReach Community Clinic. I understand that in the case of termination, I will not be able to apply for assistance in the future. I further understand that services are suspended or terminated at the sole discretion of HealthReach Community Clinic.

I also give permission for HealthReach Community Clinic to contact and verify information from other agencies and companies as it pertains to this application and the services HealthReach provides.

Signed: _____

Printed Name: _____

Date: _____



STATEMENT OF NO INCOME

If you have no monthly income, please read and sign the following statement:

I, _____, do not currently have any income, which includes but is not limited to, wages, unemployment benefits, disability benefits, self-employment income, Social Security and retirement. I understand that it is my responsibility to report to HealthReach Community Clinic the start of any income within 10 days of its beginning.

Patient Signature: _____ Date: _____

SUPPORT LETTER (**to be completed by the person/s who supports you)

I provide support for _____ (name of patient) in the following ways:

Check only one of these boxes:

- Patient lives with me at the address below and receives free room and board.
- Patient lives with me and shares expenses. My contribution to expenses is indicated below.
- Patient does not live with me, but I provide support as indicated below.

I provide cash and/or other funding in the approximate amounts indicated below:

Food:	\$ _____	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly
Housing:	\$ _____	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly
Utilities:	\$ _____	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly
Cash:	\$ _____	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly
Other:	\$ _____	<input type="checkbox"/> weekly	<input type="checkbox"/> monthly

(please explain Other): _____

Sign your name

Your relationship to patient (e.g., friend, parent, neighbor)

Print your name

Phone number

Print your street address

City

State Zip



HEALTHREACH
Community Clinic

Patient Health History Form - Confidential

Today's Date: _____ Social Security #/ TIN #: _____ Date of Birth: _____

Mr. Mrs. Ms. First _____ Middle _____ Last _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Can we text you? No Yes

Sex: Male Female Email address: _____

EMERGENCY CONTACT: Name: _____ Phone Number: _____ Relationship: _____

May we share information from your medical record with this person? Yes No

Primary Language:	Race:	Ethnicity:	Marital Status:	Last Level of School Completed:
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please list): Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other:	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partner	<input type="checkbox"/> Less than high school <input type="checkbox"/> Some high school <input type="checkbox"/> High school/GED <input type="checkbox"/> Some college <input type="checkbox"/> College graduate <input type="checkbox"/> Graduate school

Are you a veteran? No Yes If yes, what branch? _____ Dates of service _____

Do you have medical insurance? No Yes Have you applied for Medicaid in the last 12 months? No Yes

Have you been approved for Family Planning? No Yes

Date denied/approved: _____ If denied, please include a copy of your Medicaid Denial Letter.

Have you applied for Food Stamps? No Yes If yes, do you receive Food Stamps? No Yes

Current Employer, if any: _____ City: _____ State: _____

Type of job you do: _____

We will not contact your employer. This information helps us understand your activities and what conditions you work in.

Are you ALLERGIC to any medication, food, or latex? No Yes

If yes, please list: _____

Please list MEDICATIONS that you are currently taking, including name of drug, milligrams, and how often you take it.

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Do you have a regular physician? If so, what is his/her name? _____

Patient Health History Form - Confidential
(Continued)

Have you had or do you presently have any of the following medical conditions:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Acid Reflux/Ulcers | <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dental Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Anticoagulation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Peripheral Arterial Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> (Type I or Type II) | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Major Blood | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Vessel Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Bowel Diseases | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> GERD | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Blood Plasma | <input type="checkbox"/> Gout | <input type="checkbox"/> Musculoskeletal Disease | <input type="checkbox"/> Transfusions |

Infectious Diseases:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Guinea Worm | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cholera | <input type="checkbox"/> Malaria | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Trachoma |
| <input type="checkbox"/> Dengue | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Ebola | <input type="checkbox"/> Parasite Infection | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Poliomyelitis | |
| <input type="checkbox"/> Filariasis/Elephantiasis | <input type="checkbox"/> Rheumatic Fever | |

- Cancer (type) _____
 Heart Disease _____
 Hepatitis _____
 Venereal Disease _____

Is there anything else that you would like to tell us about you and your situation?
Example: "The house I stay in does not have electricity." Or "I used to work in a coal mine."

Please List Any Prior Hospitalizations/Surgeries/Major Illnesses and their Month/Year

Use of Tobacco Products: Never Rarely Moderate Heavy Quit

Quit Date: _____ Years Used: _____ Packs per Day: _____

Use of Alcohol: Never Rarely Moderate Daily (type) _____ Quit date: _____

Use of Drugs: Never Rarely Moderate Daily (type) _____ Quit date: _____

Have you ever shared needles? Yes No

Caffeinated Drinks Per Week: _____ Exercise: Type: _____ Events/Week: _____

How did you hear about HealthReach Community Clinic? _____



Consent to Treatment, Authorizations and Notice to Patients

Authorization for Treatment: I hereby request and consent to the rendering of health care by the HealthReach Community Clinic. I understand that this clinic is staffed by a health care team which may include physicians, nurse practitioners, physician assistants, nurses, technicians, and other volunteers. I accept that health care services may take place remotely via telehealth or telephone and understand that participation in remote care is completely voluntary. I freely accept care from this health care team and acknowledge the establishment of the provider-patient relationship. I further understand that this health care team will provide information and/or care; however, I maintain the right to make all decisions regarding my care. I understand that no guarantee or assurance has been made as to the results that may be obtained. This consent is to remain in effect until it is revoked by me in writing. I understand that I have the right to revoke this consent at any time.

By signing this consent, I acknowledge that the HealthReach Community Clinic is a nonprofit entity that solely provides free health care services and is qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. I further acknowledge that I have been notified that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. Sections 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage is limited, and applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. Section 233(a)(o)). Certain free clinic health care practitioners providing health care services to patients at this free clinic may be covered by the above Federal law.

Authorization to Release Medical Information: I authorize the HealthReach Community Clinic to release information from my medical record to any health care provider participating in my care. I understand that following the release of medical records or information, the HealthReach Community Clinic will no longer be responsible for the confidentiality of any documents or information released in accordance with this authorization. I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it.

A health record locator service/health information exchange (HIE) allows my health care providers to electronically access my health information held by other participating providers to provide me with better care. I authorize HealthReach Community Clinic to access any of my health information that is available in an HIE, and HealthReach Community Clinic will also make my health information available through HIEs in which I participate unless I submit a completed form specifically requesting to opt out.

Signature of patient or legal guardian

Date/Time

Witness

Date/Time