HEALTHREACH
Community Clinic

Revised February 2022

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 be at or below 300% of the Federal Poverty Level.
4. You must fill in all sections of the application packet and return the **completed** forms with **PROOF OF INCOME**.
5. You must present a valid picture ID.
6. 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
7. 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 an 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
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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 a 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 (signature page – page 8)

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 months 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 benefits letter)
- Unemployment Benefits (copy of awards letter or printout of weekly payment)
- Workman's Compensation Benefits statement
- Housing Assistance Letter

— **If you have no income**, you must complete the **Statement of No Income** (page 4). Also, the person(s) who supports you must complete and sign the **Support Letter** (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 narcotics or controlled substances on our premises.

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:	$_____	☐ weekly	☐ monthly
Housing:	$_____	☐ weekly	☐ monthly
Utilities:	$_____	☐ weekly	☐ monthly
Cash:	$_____	☐ weekly	☐ monthly
Other:	$_____	☐ weekly	☐ 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:**
☐ English ☐ Spanish ☐ Other **(please list)**: **Do you need an interpreter?** ☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ Other:	☐ Hispanic/Latino ☐ Non-Hispanic	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner	☐ Less than high school ☐ Some high school ☐ High school/GED ☐ Some college ☐ College graduate ☐ 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

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 <u>MEDICATIONS</u> 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:

__Acid Reflux/Ulcers
__Allergies
__Anemia
__Anticoagulation
__Anxiety
__Arthritis
__Asthma
__Bowel Diseases
__Bleeding Tendency
__Blood Plasma
__COPD
__Dental Disease
__Depression
__Diabetes
(Type I or Type II)
__Diarrhea
__Epilepsy
__Eye Disease
__GERD
__Gout
__Hyperlipidemia
__Hypertension
__Kidney Disease
__Liver Disease
__Low Back Pain
__Major Blood
Vessel Disease
__Migraines
__Multiple Sclerosis
__Musculoskeletal Disease
__Neuropathy
__Osteoporosis
__Obesity
__Peripheral Arterial Disease
__Prostate
__Skin Disorder
__Sleep Apnea
__Stroke
__Thyroid
__Transfusions

Infectious Diseases:

__AIDS/HIV
__Cholera
__Chicken Pox
__Dengue
__Ebola
__Encephalitis
__Filariasis/Elephantiasis
__Guinea Worm
__Malaria
__Measles
__Mumps
__Parasite Infection
__Poliomyelitis
__Rheumatic Fever
__Scarlet Fever
__Tetanus
__Trachoma
__Tuberculosis
__Whooping Cough

__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: _____

Have you had a COVID vaccine? __Yes __No If yes, how many doses?_____

Which manufacturer? (Circle) Pfizer Moderna Janssen (J&J)

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

Section III. Social/Emotional Health

10. How would you rate your quality of life right now (by that we mean your emotional well-being, life satisfaction and/or happiness)?

    1 - Poor 2 - Fair 3 - Good 4 - Very good 5 - Excellent

11. In the past year, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable) because you can't afford your medications?

    1 - Not at all 2 - A little bit 3 - Somewhat 4 - Quite a lot 5 - Extremely

12. In the past year, due to your emotional health, how much have you become isolated (ex. decreased social activities with family/friends, not getting out and doing things)?

    1 - Not at all 2 - A little bit 3 - Somewhat 4 - Quite a lot 5 - Extremely

13. In the past year, due to your emotional health, how much has your daily routine been affected (ex. unable to do your usual tasks/activities at home and/or at work)?

    1 - Not at all 2 - A little bit 3 - Somewhat 4 - Quite a lot 5 - Extremely

Section IV. Open-Ended Questions

14. Are you currently enrolled in any other program/services for assistance with your physical health, emotional health, and/or financial problems?

    ☐Yes ☐No

    If yes, please list: _____

15. We understand the difficulty you must be facing, and we would love to hear what led you to NC MedAssist. *(Optional)*

    _____

    _____

    _____

    _____

    _____

Applicant's Agreement/Disclosure/Release

I attest that the information I have given in this enrollment application is accurate and true. I also understand that even if my application is approved, services are not guaranteed. By signing this application, I release NC MedAssist, its affiliated drug companies and any public or private agencies or financial supporters and their agents, from any and all claims of liability in contract or tort arising out of the actions of NC MedAssist, its agents, employees, or P.O.E in performing services or related to services I receive from NC MedAssist. I give my consent to DSS and DHHS to advise NC MedAssist of the status of a pending Medicaid application. **I will promptly notify NC MedAssist if I become eligible for Medicare, Medicaid, private insurance or VA benefits, or if my income changes.** I also give consent to NC MedAssist to disseminate my health information to its affiliates (i.e. audits by pharmaceutical companies) as it pertains to all federal, state and local laws and regulations and purposes directly related to the administration of NC MedAssist programs and grants. I have received NC MedAssist's Notice of Privacy Practices Statement. I give my permission to NC MedAssist to sign my name on Patient Assistance Program documents when necessary.

Patient Signature_____Date_____

For office Use Only

Date Entered_____ Temp Date_____ Recert Date_____ POE_____

NC MedAssist Employee Signature_____ Date_____