HealthReach Community Clinic
400 E Statesville Ave, Ste 300
Mooresville, NC 28115

Phone: (704) 663-1992
Fax: (704) 663-2073

Patients@healthreachclinic.org

PATIENT APPLICATION

Revised March 2025

Applicant (Patient)'s Name (print):_____

HealthReach is a not-for-profit medical clinic run mostly by volunteers. We rely on donations to serve our patients. We are not affiliated with any hospital system or government agency. Our services are limited to **basic, non-emergency health care** and **does not** include dental care.

Eligibility Guidelines

1. You must be an Iredell County or Town of Davidson resident, 18 years or older.
2. You must not have any form of health insurance, including Medicaid or Medicare.
3. You must be at or below 300% of the Federal Poverty Level (see chart on page 3).

One application is only for one person. Each person who wants to apply must fill out an application.

HealthReach reserves the right to determine who can become a patient and the right to dismiss patients who do not follow clinic policies. See the HealthReach Patient Handbook for more information about clinic policies and guidelines.

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

By signing below, I certify that:

1. I understand the contents of this application and agree to follow the clinic's policies if approved as a patient, as described in the HealthReach Patient Handbook.
2. I believe that all information that I have submitted within this application to be true and accurate.
3. I understand that knowingly submitting false information puts me at risk of permanent dismissal from the clinic and all services.

Applicant's Signature_____Date_____
Patient/Authorized representative*

*****If Authorized Representative, please indicate relationship to patient:

_____Spouse _____Parent _____Other (Please specify) _____

For admin use only:

Patient name: Submit date: Cert date:

APPLICATION INSTRUCTIONS

Completed applications can be submitted by mail, email (listed on page 1), or in-person during our open hours. It may take up to 2 weeks to process your paperwork. Submitting incomplete applications or applications with missing documents can further delay processing. HealthReach will reach out to you over phone once your application has been processed, and you may schedule an appointment if/when you are approved as a patient.

Use the checklist below to help you know which documents you will need to submit:

Did you file taxes this year? ☐ No ☐ Yes

If yes, please include: ☐ Federal Tax Return (Form 1040) and W-2s

☐ Spouse and/or children's W-2s and tax returns (if applicable)

☐ Medicaid letter explaining benefits and/or card (if applicable – see front desk for which limited plans are acceptable, i.e., Family Planning only)

☐ Photo ID (drivers' license, passport, etc.) **APPLICATIONS WILL NOT BE ACCEPTED WITHOUT ID**

☐ Proof of residency (e.g., utility bill or piece of mail showing valid Iredell County or Davidson address)

☐ Signed NC MedAssist Application (signature page included on last page)

☐ Proof of income for **EVERY** member of the household over the age of 18 (see page 3 to see who is included in the household)

- ☐ If you have no income:
  - ☐ Signed Statement of No Income (page 4, top)
  - ☐ Support Letter (page 4, bottom) signed by the person(s) who supports you **OR** complete bank statement for 1 month (if using savings/between jobs)
- ☐ If working:
  - ☐ Last 4 pay stubs (consecutive) **OR** a letter from your employer on company letterhead listing your rate of pay & regular weekly hours (an Employment Verification form is available at the front desk if needed)
  - ☐ **AND** 2024 W-2(s)
- ☐ If self-employed:
  - ☐ Complete bank statements for the last 3 consecutive months
  - ☐ Federal tax return for 2024 with **All Schedules**
  - ☐ Signed Self-Employment Form (available at the front desk)
- ☐ 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)
- ☐ Workman's Compensation Benefits statement

Please speak with front desk staff if you need assistance in submitting any documents.

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Patient Household Information

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.			$
8.			$

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

A patient's household income is determined by **the household members**: the individual patient, as well as anyone else who lives in the same household. **Anyone over the age of 18 in the household with income must also provide proof of their income (see page 2).** Roommates and landlords are not considered to be part of the patient's household. To be eligible as a patient at HealthReach, the patient's household must not make over **300% of the Federal Poverty Level (FPL)**. The income cut-off is listed below, according to household size:

300% of Federal Poverty Level, **2025**

Family Size (everyone in household)	Monthly Income (before tax)
1	$3,912.50
2	$5,287.50
3	$6,662.50
4	$8,037.50
5	$9,412.50
6	$10,787.50
7	$12,162.50
9	$13,537.50
For each additional person, add:	+ $1375.00

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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, salary/wages, unemployment benefits, disability benefits, self-employment income, Social Security benefits, or retirement benefits. I understand that it is my responsibility to update HealthReach Community Clinic of any changes to my income within one (1) month.

Patient Signature: _____Date: _____

LETTER OF SUPPORT (to be completed by the person who supports you)

I provide support for _____(name of patient) as follows:

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 share of expenses is listed below.
- ❑ Patient does not live with me, but I provide support as listed 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): _____

_____ _____ _____
Signature of Support | Your relationship to patient (e.g., friend, parent) | Date

_____ _____
Printed Name | Phone number

_____ _____ _____ _____
Street address | City | State | Zip

HEALTHREACH Community Clinic

Patient Health History Form – Confidential

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

First_____ Middle_____ Last _____

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

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

☐ Male ☐ Female ☐ _____ Email address: _____

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

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

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 Medicaid? ☐ No ☐ Yes

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

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 ALL MEDICATIONS that you are currently taking, including name of drug, strength, and directions.

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

Patient Health History Form - Confidential
(Continued)

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

☐Anxiety
☐Bipolar disorder
☐Depression
☐Drug/alcohol dependency

☐Asthma
☐Blood disorder
☐COPD
☐Diabetes
☐Type 1
☐Type 2

☐Acid reflux/GERD
☐High blood pressure
☐Kidney Disease
☐Liver disease
☐Stomach ulcers

☐Abnormal mammogram _____

☐Cancer (type) _____

☐Heart Disease _____

☐Hepatitis ☐ **A** ☐ **B** ☐ **C**
☐HIV
☐Stroke (list month/year) _____
☐Tuberculosis
☐Other

_____

_____

Hospitalizations (list month/year): _____

_____

Surgeries (list month/year): _____

_____

Family history: ☐Cancer_____ ☐Heart attack_____ ☐Other _____

Tobacco: ☐Dip ☐Chew
Smoking: ☐Current ☐Former
Years Used: _____ Packs per Day: _____
Vaping: ☐Current ☐Former
☐CBD ☐Nicotine
Alcohol: # of drinks per ☐Day _____ ☐Week _____
Drug use: ☐Current ☐Former ☐Type _____

Have you had a COVID vaccine? ☐No ☐Yes (list # of doses) _____

Have you ever been diagnosed with COVID? ☐No ☐Yes (list month/year) _____

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 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 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.

Authorization to Release Medical Information: I authorize 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, 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

Patient Contact Consent Form and Questionnaire

Patient Name:_____

Patient Date of Birth:_____

Mailing address:_____

Contact Information and Preference:

Are we allowed to email you? Yes No

If yes, best email address to receive messages:_____

Are we allowed to call you? Yes No

If yes, best number to receive phone calls:_____

What is the best time of the day for us to call?_____

Are we allowed to leave voicemails? Yes No

Are we allowed to text you? Yes No

If yes, best number to receive text messages:_____

What information can we share with your emergency contact?

☐ Health & Appointment Info ☐ Appointment Info Only
☐ Health Info Only ☐ Call Return Messages Only

I hereby consent to receive emails, phone calls, and text messages from my healthcare providers at HealthReach Community Clinic based on the responses above. I understand these messages may include medical information such as lab results, notes from my visit, medication information, etc. I understand that if my emergency contact access needs change at any time, I will inform the clinic of this change in writing.

Date:_____

Patient Signature:_____

4428 Taggart Creek Rd
Suite 101
Charlotte, NC 28208
Toll Free: 866.331.1348
Local: 704.536.1790
Fax: 704.536.9865
www.medassist.org

Free Pharmacy Program Application

Please complete pages 1-3. Sign your name on page 3 and submit with your supporting documents. See previous page for application instructions.

Patient Information

First Name:	MI:	Last Name:	SSN /ITIN(W-7):	Birth Date:
Mailing address:		City:	State: **NC**	Zip:
County in North Carolina:		Primary Phone #:	Emergency Contact Name/Phone/Relation:	
Please list any medication allergies that you have:		Email Address:		

Demographics

Check all that apply: ☐Disabled ☐LGBTQIA+ ☐Veteran or Military Family ☐Justice-Involved

Primary Language(other than English): ☐Spanish ☐Chinese ☐French ☐Arabic ☐Vietnamese ☐German ☐Hindi ☐Telugu ☐Russian ☐Korean ☐Portuguese ☐Tamil ☐Hmong ☐Tagalog ☐Other:

Gender: ☐Male ☐Female ☐Non-binary	Marital Status: ☐Single ☐Married ☐Separated
Race: ☐ White or Caucasian ☐ Black or African American ☐Asian ☐American Indian ☐ Bi-racial of Multi-racial ☐Native Hawaiian or Pacific Islander ☐ Other:	Number of People in Household Including Self: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 Other:
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	How did you hear about the program? ☐ Doctor/Clinic/Hospital ☐ Flyer ☐Friend/Family ☐ Facebook ☐ Event ☐ Other:
Please check if you have any of the following: ☐Health Insurance ☐ Medicare ☐Medicare Part D ☐ Medicaid ☐VA Health ☐Other	If applicable, Name of Enrollment Site or Sponsoring Point-of-Entry(Enter site code):
Do you struggle with substance use? ☐Yes ☐No If yes, are you interested in receiving help? ☐Yes ☐No	Do you use tobacco(smoking, vaping, chewing)? ☐Yes ☐No If yes, are you interested in quitting? ☐Yes ☐No

Patient Income

List and Attach all Household Income:

Salary/Wages	$_____
Disability	$_____
Alimony/ Child Support	$_____
Social Security	$_____
Pension/Retirement	$_____
Unemployment/Work Comp	$_____
Gross Monthly Income	**$**_____
Total Gross Annual Income	**$**_____

Attach Proof of Income or No Income
Please see the application instructions to find a list of approved income documents. If married, please include income of spouse.

All income must be dated from within the last 60 days. Annual statements must be dated this year.

Did you file taxes this year?
☐Yes ☐No

Next, you will find our Health Survey that must be submitted with your application. The information we gather from these surveys helps us to get funding for NC MedAssist and continue providing you with medications you need at no cost. Your responses allow us to tell how this service improves your health and quality of life. Please answer the questions to the best of your ability by circling, checking or filling in your answer.

Section I. Physical Health ***Patient ID:_____***

1. Prescription Medications

    a. Are you taking all the medications as prescribed by your doctors?
    ☐Yes ☐No

    b. Do you skip taking medications as prescribed by your doctors?
    ☐Yes ☐No ☐Sometimes

2. In the past year, how many times did you go to the emergency room? _____ times

3. In the past year, how many times did you stay overnight in the hospital? _____nights

4. How would you rate your current health?

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

5. In the past year, how much were your physical health activities limited due to health problems?

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

Section II. Finance/Employment

6. Are you currently employed? ☐Yes ☐No

    If yes, How many hours do you work per week? _____

7. How much do you struggle to cover basic living expenses (e.g., food, housing, transportation, bills)?

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

Section III. Social/Emotional Health

8. 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

9. In the past year, how much have you been bothered by emotional problems (such as feeling anxious, depressed, isolation, 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

10. In the past year, 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. General Questions (Optional)

11. Because I need to pay for my medication, I have not been able to pay for: (mark all that apply)

☐ Groceries
☐ Money into a savings account
☐ Other bills
☐ Basic living expenses (rent, utilities, bills)
☐ A car payment or for transportation
☐ Others (please list): _____

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 am app 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 hereby authorize NC MedAssist and its designated representatives to utilize a third-party electronic income verification system to verify my household income and address for the purpose of determining my eligibility. 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_____ Recertification Date_____POE_____

NC MedAssist Employee Signature_____ Date_____

Notice of Privacy Practices

NC MedAssist values your privacy. This notice explains what information we collect, how we use it, and how we protect it.

What We Collect

To provide you with free prescription medications, we may collect:

- Proof of income (such as tax returns, pay stubs, Social Security letters, or letters of support)
- Prescriptions written by your healthcare provider
- Basic personal information like your name, date of birth, gender, address, and phone number
- Photograph or biography if needed for identification or program purposes

We may also ask you to complete a health survey. These surveys do not collect your name or personal identifiers and are used only to measure how our services help the community.

How We Use Your Information

- NC MedAssist partners with many pharmaceutical companies, each with their own eligibility rules.
- Your file may be reviewed (audited) by these companies to ensure we follow their requirements.
- These reviews are required for us to provide you with free medications.

Your Information Is Never Sold or Shared for Marketing

We do not sell or share your personal information. We will never share your personally identifiable information or protected health information (PHI) with any outside organizations, including but not limited to:

- Government agencies
- Funders or foundations
- Marketing or media companies

Your data is used only to help us provide your medications and meet required program rules.

Occasional Contact

We may contact you to ask if you'd like to share a story or testimonial about your experience. You may choose to say yes or no—your care will never be affected by your decision.

Questions?

If you have any questions about how your information is used, please call us at 704-536-1790.