ANDERSON FREE CLINIC – New Patient (in Anderson) Screening and re-certification

New patients may apply for services <u>on Wednesday mornings.</u> The doors open at 9:00 and closes at 9:05 to allow us to give important information to all applicants <u>at the same time</u>. Applicants sign in and see a screener for the initial intake process. This does not guarantee that you automatically qualify for services. You will not become a patient that day. A meeting with the screener is only the first step in this process. If you qualify, you will be called & meet w/ our intake coordinator. **It may take up to 4 months until you are scheduled a first visit w/ a provider**

Re-certifications are done on a walk-in/sign in on Wednesday at 12 pm and Fridays at 9 am, or by mail.
If you send your re-certification by mail, the form and all documents must be sent together. We are not able to contact you about documents you missed. If anything is missing, your re-certification will not be processed.
Patient will be considered NEW PATIENT if he or she does not re-certify for 2 or more years (based on last certification date).

Applicants to become a patient **or** current patient re-certifying **MUST BRING ALL THAT APPLY FROM LIST BELOW, OR THEY WILL BE ASKED TO RETURN ANOTHER DAY.** No exceptions!!!!

OMITTING EXISTING DOCUMENTATION AND INCOME WILL BE GROUNDS FOR DISMISSAL FROM THE CLINIC.

- **<u>Most recent tax return.</u>** <u>If tax return was not filled for most recent year, bring W2 , form 1099, 1099G, 1099INT</u>
- <u>Proof of income—please bring all that apply:</u> Paycheck stubs (one month's worth); Proof of child support or alimony; Social Security award letter; Pension or 401(k) statement; Unemployment benefits. If paid in cash, a statement from the employer indicating the amount paid (must be signed and dated on a company letterhead).
- Current checking/ savings account.
- **If you are claiming no income, the form below must be completed, signed, & dated <u>by the person providing support</u>**.

Note: Misrepresenting someone is cause for dismissal or refusal to accept the person as a patient

- <u>Supplemental Nutrition Assistance Program (formerly Food Stamps) benefit history letter</u>
- <u>Statement from employer stating health insurance is not provided - signed / dated on a company letterhead</u>
- <u>Picture ID of the person applying, that shows proof of residence in Anderson County</u>
- <u>Social Security cards for each person in the household</u>
- <u>$15 – cash, money order or check accepted. This is an Annual Certification Fee, not a visit or co-pay charge.</u>

<u>What patients must know:</u> The Free Clinic provides medical & dental care & prescription assistance to patients seen at the Clinic

To be our patient you must live in Anderson County, with household income below 100% Federal Poverty Level. If you are on Medicaid, Medicare or have private insurance you do not qualify to become our patient.

We are here to care for your health, making best use of volunteer's time & limited resources! We expect you to do your part. That includes: get your labs done in time, take meds as prescribed and get refills before you run out, bring all med in original bottle to every visit, do not disregard (miss) appointments, and if cancelling do it in advance, so we can fill it, be courteous …

<u>We do not…</u> fill out disability forms or statements asking if you can work. **<u>We do not</u>** dispense or fill prescription for narcotics, and have no resources to treat chronic pain or mental illness. **<u>Patients cannot</u> …** ask to see a specific doctor… call volunteer doctor outside the Free Clinic… ask doctor to make their case look worse on the chart to help on their disability "case".

We exist because people donate to the Free Clinic. No donation is too small **and patients are asked to pitch in!**

If you are claiming no income, complete this: **ANDERSON FREE CLINIC SUPPORT VERIFICATION FORM**

*I,*_____*(applicant) , resident at* _____ _____

Person who wants to be a Free Clinic patient *Street* *City* *Zip*

am applying to become (or re-certify as) a patient of ANDERSON FREE CLINIC & declare that I have not received/earned income in the past ___ years ___ months and receive help from other people.

Because of the statement made above, the following must be completed by the person who is GIVING SUPPORT to the Applicant. If more than one person if providing support, add information on the back of this form.

Your name (the supporter): _____ Relationship to the patient: _____

How long has the above person lived at the address listed above? _____

Check ALL support provided by YOU to the above named applicant

_____ Food _____ Cigarettes ____ Medication ____Gasoline for car ____Money for bus

_____ Financial Support (money given directly to the applicant). How much EACH month? $_____

_____ Other. Please list: _____

_____ Shelter at the above listed address ___ Check here if you share a residence w/ the above named applicant.

Do you file taxes together with the applicant or can you claim him/her as your dependent? ____ Yes ___ No I expect to provide this support until: _____Daytime ph # _____ The Free Clinic may call you to confirm information ***By dating & signing below I certify that the above information is correct***

Date: _____ Signature of the person giving support (<u>not</u> the patient)_____

Anderson Free Clinic

☐ **New Patient Application** ☐ **Recertification** Date completed: / /

Last Name _____ First_____ MI_____

Address: _____

City_____ State_____ Zip_____

Phone (____)_____ Cell Phone (_____)_____ Alt. Phone (_____)_____
(Circle the main contact ph #)

SS# _____-_____-_____ Birth Date _____/_____/_____ Sex ☐ Male ☐ Female

Emergency Contact: _____ _____ (____) _____
Name Relationship Phone

Total people living in household and their relationship to you: ____ Yourself and

_____ , _____,

_____,_____ , _____,

_____ , _____,

Do you live in Anderson County?	☐ YES	☐ NO*		
Do you have private insurance?	☐ YES*	☐ NO	☐ NO BUT I AM ELIGIBLE	
Do you have Medicaid?	☐ YES*	☐ NO	☐ NO BUT I AM ELIGIBLE	
Do you have Medicare?	☐ YES*	☐ NO	☐ NO BUT I AM ELIGIBLE	
Are you a veteran?	☐ YES	☐ NO		
Do you have VA benefits?	☐ YES*	☐ NO		
Do you receive Food Stamps?	☐ YES	☐ NO		
Did you file taxes last year?	☐ YES	☐ NO		
Did you file taxes this year?	☐ YES	☐ NO		

Housing Status
- ☐ Own
- ☐ Friend ☐ Relative
- ☐ Rent, no public assistance
- ☐ Public Housing ☐ Section 8
- ☐ Homeless Shelter _____
- ☐ Homeless/Street
- ☐ Haven of Rest/Transformation Life
- ☐ Other _____

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ In Common-Law Marriage

Education Level
- ☐ Grade School
- ☐ Some High School
- ☐ High School Graduate
- ☐ GED
- ☐ Some College
- ☐ College Graduate

Race/Ethnicity
- ☐ Caucasian
- ☐ African American
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Other _____

Employment Status
- ☐ Employed Full Time
- ☐ Unemployed
- ☐ Employed Part Time/ Temp
- ☐ Retired
- ☐ On Social Security Disability

Allergy Alert:

___ None

Primary Language

☐ English ☐ Spanish ☐ French ☐ Other _____

Can understand English without an interpreter? ☐ YES ☐ NO

Monthly Household Income: Salary/Wages: Self _____ Spouse _____ Others_____+

Total Household Salary _____

Social Security _____ Veteran's Benefits _____

SSI _____ Unemployment Benefits _____

Child Support _____ Food Stamps _____

Housing Allowance _____

Cert/Recert Fee paid on _____

TOTAL:

To be completed by AFC
APPROVED UNTIL :

Medical Information

Why are you here? ☐ I'm having medical problems ☐ I'm having teeth problems ☐ I'm filing for disability and need more documentation ☐ Other _____

Please check if you have any of the following health conditions: ☐ Are you pregnant? ☐ Yes ☐ No

☐ Diabetes	☐ COPD (lung disease)	☐ Dental Problems	☐ Excessive Thirst
☐ Asthma	☐ Congestive Heart Failure	☐ Excessive Urination	☐ Seizures
☐ Cancer	☐ Heart Disease	☐ Stroke	☐ Arthritis
☐ Chest Pain	☐ Shortness of Breath	☐ HIV/AIDS	☐ Kidney Disease
☐ Mental Illness	☐ High Blood Pressure	☐ Heart Attack	☐ Hepatitis
☐ Sleeping Problems	☐ Fast weight loss or gain	☐ Constant muscle pain	☐ Blurry Vision

☐ Pain, Numbness, and tingling in the arm, wrist, hand, or fingers

☐ Change in urination like: difficult urinating, holding back urine, slow urine flow (circle)

Do you smoke? ☐ No, never ☐ No, I quit When: ____ ☐ Yes # of packs per day ____ For how many years? __

Are you taking any medication? ☐ No ☐ Yes* List: _____

_____

_____

FAILURE TO LIST ALL MEDICATIONS WILL RESULT IN APPLICANT BEING REMOVED FROM THE LOTTERY AND POSSIBLE DISMISSAL FROM CLINIC SERVICES. (*If yes, MUST bring all medications to intake appointment)

What activities would you like to do, but can't because of your health?_____

_____

How is your health preventing you from the activities listed above? _____

_____

_____

Please check if your parents or siblings have a history of: ☐ Cancer ☐ Diabetes ☐ Heart Attack ☐ Heart Disease ☐ High Blood Pressure ☐ Respiratory Problems ☐ Stroke

Are you allergic to any medications? ☐ No ☐ Yes* If Yes, please list: _____

Have you been seen in the emergency room in the last 6 months? ☐ Yes ☐ No

*If Yes, which one(s): _____ Reason:_____

Have you been admitted to the hospital in the last 6 months? ☐ Yes ☐ No

*If Yes, which one(s): _____Reason:

When was the last time you saw a doctor? _____ For what reason?_____

When was the last time you saw a dentist? _____ For what reason?_____

Receiving support from other organizations does not affect your eligibility at the Free Clinic. I will only support each other's work!

Check if you have received support from these organizations <u>in the past 12 months:</u> AIM/Food Pantry___ AIM/Other:_____ Safe Harbor___ Soup Kitchen on Franklin St ___ Other Soup Kitchen___ Salvation Army ___ Sunshine House___ Foothills Alliance ___ Haven of Rest___ Clean Start___ Church (names): _____ _____ Other:_____ I do not receive support from other organizations ___

I certify the above information is correct.

I understand that completing this application does not guarantee I will be eligible for services from the Anderson Free Clinic.

I understand that any false or incomplete information on this form may result in ineligibility or dismissal as Free Clinic patient.

*<u>New Patient (in Anderson)</u>: I authorize the Free Clinic to leave a message and appointment date in case my name is drawn in the lottery **(if not, please cross off).** I understand that only one call will be made with my first appointment date, with no reminders.*

<u>Anderson Patients recertifying</u>: I understand that if I am recertifying by mail and do not provide all necessary information , I will not be contacted about missing information and my recertification will be on hold until the next time I contact the clinic, with risk of me losing my status as Free Clinic patient.

I have read and understood the Anderson Free Clinic's Patient Rights and Responsibilities. I agree to abide by the Free Clinic's rules and regulations while I am a patient at the Anderson Free Clinic or Honea Path Free Clinic.

Patient/Guardian Signature _____ Date _____

<u>Clinic Staff Use Only</u>: Screened by: _____ Date:_____ Eligible? ☐ Yes ☐ No ☐ Need opinion Letter

Employee Health Insurance Eligibility Form

Company name: **Date completed: / /**
Company Contact Name/ Title:
Company Contact phone number:
Employee Name:

Do you (the employer) offer health insurance to the above employee? YES NO

If you (the employer) offer health insurance,is the above employee eligible to enroll in the insurance plan?

YES NO If no, why not:

Has the employee declined the health insurance(s) plan(s) available? YES NO

Does the employee have to pay a portion of the health insurance premium? YES NO

Do you (the employer) offer more than one insurance plan option, with different levels of coverage and/or deductible? YES NO

If the answer above was YES, please list the Plan(s), type of deductible, scope of the plan, amount employee pays and what percentage does amount corresponds to the employee's salary <u>for every option available</u>

PLAN
Deductible
Amount paid by employee
That correspond to ____% of this employee's salary
Does it include: Vision Care YES NO Dental Care YES N

PLAN:
Deductible
Amount paid by employee
That correspond to ____% of this employee's salary
Does it include: Vision Care YES NO Dental Care YES NO

PLAN
Deductible
Amount paid by employee
That correspond to ____% of this employee's salary
Does it include: Vision Care YES NO Dental Care YES NO

Please give a copy to employee and fax a copy on company letterhead by:_____
deadline date

to: (864)261-4543
Anderson Free Clinic
att: Patient Services Coordinator, Sandra Brooks

Anderson Free Clinic

Phone 864-226-1294
Fax 864-261-4543

REQUEST FOR MEDICAL RECORDS

DATE: _____

Doctor/Facility or Office

_____
Name of facility/Doctor

_____
Street

_____
City ST ZIP

_____ _____
Ph Number Fax Number

Doctor/Facility or Office

_____
Name of facility/Doctor

_____
Street

_____
City ST ZIP

_____ _____
Ph Number Fax

For the continuation of my health care,
I hereby authorize the above physicians, hospitals, or attendants
to release my medical records for the last **12 months**

_____

To: the Anderson Free Clinic
414 North Fant Street
Anderson, S.C. 29621

Patients Name: _____

Social Security: _____-____-_____ DOB: _____

Patients Signature: _____

Witness: _____

TO: All Patients of the Anderson & Honea Path Free Clinics
FROM: Barb Baptista, Anderson Free Clinic Executive Director

Despite the contributions we receive, the cost to serve ONE patient for <u>one year</u> is approximately $300. The cost of operating the clinic has risen greatly. At the same time, grants and donations have decreased. The Free Clinic does not receive any government funding.

In order to continue to offer the best healthcare possible to the largest number of patients, the Anderson Free Clinic Board of Directors voted to charge a Certification Fee to all patients. Effective January 1st, 2014, each patient will be charged an annual $15 certification fee which will be valid for 12 months. This will be due at the certification or recertification date.

<u>The following will apply to current and new patients at our Anderson and Honea Path Clinics</u>

- For current patients**, the $15 annual certification fee will be** due at your next recertification date and paid to the Intake Coordinator.
  - Mail in recertifications **will be accepted if accompanied by a money order or check for the $15 fee (no cash) made out to *Anderson Free Clinic.***
  - Drop off recertifications **can be paid with cash (ask for a receipt) or check made out to *Anderson Free Clinic*.**
  - No certifications will be done without the fee.
- New patients **whose name has been drawn from the lottery must pay the fee upon meeting for the final screening with the Certification Volunteer (for Honea Path) or the Intake Coordinator (for Anderson patients.)**
- Hospital discharges **must pay the fee at the first doctor's visit (pay at check in.)**

We ask for your strong commitment to help us continue to offer services you need. **Others may help you: family members and/ or friends might like to sponsor your care or to give you the gift of health care as a birthday or other type of present.**

Thank you for your understanding and cooperation.
We are all working together to make a difference in your lives!