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

Date completed: / /

☐ **New Patient Application** ☐ **Recertification**

Check and complete:
__ I have no children
__ I'm a parent of # ____ child/children
__ I'm a step parent of # ___ child/ren
___I'm a guardian of # ___ child/children

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 to you Phone

Name of people living where you live and their relationship to you: Yourself and :

1:_____ Relationship to you_____ 4:_____ Relationship to you_____
2:_____ Relationship to you_____ 5:_____ Relationship to you_____
3:_____ Relationship to you_____ 6:_____ Relationship to you_____

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 ☐ NO BUT I AM ELIGIBLE
Do you receive Food Stamps? ☐ YES ☐ NO ☐ NO BUT I AM ELIGIBLE
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 _____

For a transcript of your Federal Tax Return call **800-829-1040**
You file taxes as: ____ Single ___Head of the Household ___Married Filing Separately ___Married Filing Jointly Other:_____
☐ Someone claimed me on their taxes last year ☐ Someone claimed me on their taxes this year. Who? _____

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 _____
SSI _____
Child Support _____
Housing Allowance _____
Veteran's Benefits _____
Unemployment Benefits _____
Food Stamps _____

TOTAL:

To be completed by AFC
APPROVED UNTIL :

Cert/Recert Fee paid on _____

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)

Where are you currently getting your medications? _____

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 ☐ Don't know

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. **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 received support from:* ____ *Family Member* _____ *Friends Other people :*_____

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 and Certification Fee , I will not be contacted about missing information and/or fee 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

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: _____

Dear Employer:

The Anderson Free Clinic provides free medical and dental care as well as assistance with prescriptions for individuals who do not have Medicaid, Medicare or an option to obtain health insurance. Sometimes their employer offers insurance but their premium is still not affordable and on that instance we will help them. We ask all applicants who are employed to have this form completed by **their employer** to help can determine their eligibility for our services

Thank you for your cooperation.

Employer Sponsored Health Insurance Eligibility Form

Company name: **Date completed: / /**
Company Contact Name/ Title:
Signature of Contact Person: _____
Company Contact phone number:

Employee Name: _____

Do you (the employer) offer health insurance to employees? 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 **or would pay** and what percentage does amount corresponds to the employee's net salary for every option available

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

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

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

Please give the completed form to employee **after** faxing it to us stamped with your company stamp or along with a cover on your company letterhead

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