

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

New patients may apply for services on Wednesday mornings. The doors open at 9:00 and closes at 9:05 to allow us to give important information to all applicants at the same time. 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.

- **Most recent tax return.** If tax return was not filled for most recent year, bring W2, form 1099, 1099G, 1099INT
- **Proof of income—please bring all that apply:** 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 by the person providing support.** Note: Misrepresenting someone is cause for dismissal or refusal to accept the person as a patient
- Supplemental Nutrition Assistance Program (formerly Food Stamps) benefit history letter
- Statement from employer stating health insurance is not provided - signed / dated on a company letterhead
- Picture ID of the person applying, that shows proof of residence in Anderson County
- Social Security cards for each person in the household
- \$15 – cash, money order or check accepted. This is an Annual Certification Fee, not a visit or co-pay charge.

What patients must know: 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 ... **We do not...** fill out disability forms or statements asking if you can work. **We do not** dispense or fill prescription for narcotics, and have no resources to treat chronic pain or mental illness. **Patients cannot ...** 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 (not the patient) _____



Anderson Free Clinic

Date completed: / /

New Patient Application Recertification

Check and complete:

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

__ 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

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 in the past 12 months: 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.

New Patient (in Anderson): 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.

Anderson Patients recertifying: 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 _____

Clinic Staff Use Only: Screened by: _____ Date: _____ Eligible? Yes No Need opinion Letter
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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