Anderson Free Clinic

Address: 414 N. Fant Street, Anderson, SC 29621 Phone: 864-226-1294

NEW PATIENT AND RE-CERTIFICATION APPLICATION 2018

NEW PATIENTS: Please complete application and bring along with required documents any Wednesday morning at 9:00am (doors close at 9:05) for an initial screening to see if you qualify.

ALREADY A PATIENT: To recertify each year, please complete application and required documents and turn in at front window during regular business hours (we no longer accept applications that are mailed in). **No incomplete applications will be accepted** and processing takes up to 48 hours.

APPLICATION CHECKLIST (WHAT YOU MUST BRING):

Patient Name: _____ DOB: _____

- ☐ **Completed and signed application (Sections 1-8)**
- ☐ **Government ID (cannot be expired)**
  - ☐ Valid SC Driver's license (out of state driver's license only valid for 3 months per the state of South Carolina)
  - ☐ Federal or State issued ID (includes permanent or temporary residence card)
  - ☐ If no US issued ID, a Valid Passport or government ID from country of residence
- ☐ **Social Security card and Social Security cards of <u>All</u> Household members**
- ☐ **Proof of Residence in Anderson County (all documents MUST have patient name)**
  - ☐ Government ID (if it has your current address on it)
  - ☐ Utility Bill (phone, electric, water, etc.)
  - ☐ Rental Agreement
  - ☐ Tax Return or car tax receipt
  - ☐ Bank Statement or other _____
- ☐ **Proof of <u>Total Household Income</u>- you must bring in <u>ALL</u> of the following that apply:**
  - ☐ Most recent tax return or if taxes were not filed, IRS form 4506T
  - ☐ Most current check stubs (must show income for 1 full month from within the past 45 days)
  - ☐ SSA/SSI/SSDI Social Security Award letter from current year
  - ☐ Pension, 401k, retirement, or worker's comp benefits received
  - ☐ If paid in cash, a letter from the employer stating the amount paid per month (must be signed, dated, and include address and phone number for employer)
  - ☐ **Lease/Utility payment agreement if you live in HUD/SECTION 8/Subsidized housing**
  - ☐ **SNAP benefit history letter (must list current amount received)**
  - ☐ **NO INCOME FORM** (To be completed if you currently have no income)
- ☐ **Proof of NO Insurance:**
  - ☐ **Must provide a letter of denial from Medicaid** (can be requested at your local Medicaid office)
  - ☐ If employed, a signed form from employer stating that insurance is not provided
- ☐ **$15 certification fee:** (Accepted in the form of cash (please bring exact change), check, or money order. **To be paid ONLY when ALL documentation is complete.)**

NOTES:

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

SECTION 1: PATIENT CONTACT INFORMATION

First Name: Last Name: MI:

Address:

City: State: Zip:

Phone (cell): Phone (home): Phone (Alt):

Social Security #: - - Birth Date: / / ☐ Male ☐ Female

Emergency Contact: Relation: Phone:

Primary Language: Do you need an interpreter? (circle): YES NO

SECTION 2: INCOME AND INSURANCE QUESTIONS

Number of people in your household: _____ (list everyone that has lived with you for more than 1 year)

1._____Relationship to you_____ 2. _____ Relationship to you_____

3._____Relationship to you_____ 4. _____ Relationship to you_____

I filed (or was claimed on) a **2017** Tax Return: YES / NO I filed (or was claimed on) a **2016** Tax Return: YES / NO

List anyone who is listed on a tax return with you (regardless of if you live with them):

_____

Housing Status: (Check which one applies):

☐ Own ☐ Rent (no public assist) ☐ Friend ☐ HUD/Section 8/Public assist ☐ relative
☐ Shelter ☐ Haven of Rest ☐ Homeless ☐ Other_____

Do you have medical insurance from any of the following: (Check all that apply)

☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Health exchange plan ☐ VA/Military

Marital Status	Education Level	Race/Ethnicity	Employment Status
☐ Single	☐ Grade School	☐ Caucasian	☐ Employed Full Time
☐ Married	☐ Some High School	☐ African American	☐ Circle: Part Time - Temp
☐ Divorced	☐ High School Graduate	☐ Hispanic	☐ Retired
☐ Widowed	☐ GED	☐ Native American	☐ On Social Security Disability
☐ Separated	☐ Some College	☐ Asian	☐ Unemployed since
☐ Cohabitating	☐ College Graduate	☐ Other _____	_____ Month / Year

Total MONTHLY household Income: (please list ALL income for ALL members of your household listed above)

Salary/Wages: _____ (you) _____(spouse)_____(other)
SSI/SSA or Pension /Benefits: _____(you)_____(spouse) _____(other)
Child Support: _____
Housing Allowance: _____
Unemployment: _____
Food Stamps: _____

Office use only:

PF#_____

CALL BACK INFO:
Date:
Response:

Other Attempts

No show Ent:

Cert/Recert fee paid on:

To be completed by AFC:

HH SIZE: ____ Total Income: _____ ELIGIBLE: _____ CERT Expires: _____

Screened by:_____ Date: _____

SECTION 3: MEDICAL INFORMATION

Please check if you have any of the following conditions:

☐ 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 circle 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)

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

****ALLERGIES****

_____

_____

_____

☐ I HAVE NO KNOWN DRUG ALLERGIES

Smoking/Tobacco use:

☐ I have never smoked/used tobacco

☐ I quit using tobacco _____ years ago

☐ I currently smoke/use tobacco

packs per day _____ how many years_____

Medical history (Circle any conditions the following family members have had):

Mother	**Father**	**Sibling(s)**	**Maternal Grandparent**	**Paternal Grandparent**
Cancer	Cancer	Cancer	Cancer	Cancer
Diabetes	Diabetes	Diabetes	Diabetes	Diabetes
Heart Attack	Heart Attack	Heart Attack	Heart Attack	Heart Attack
Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart disease
High BP	High BP	High BP	High BP	High BP (BP=Blood Pressure)
Stroke	Stroke	Stroke	Stroke	Stroke
Respiratory	Respiratory	Respiratory	Respiratory	Respiratory (problems)
Don't know	Don't know	Don't know	Don't Know	Don't know

Date of last Doctor Visit: _____ Date of last Dentist Visit: _____

Did you go to the hospital in the past 6 months? YES /NO

Name of Hospital: ___ _____Reason: _____

Other health concerns:

SECTION 4: CERTIFICATION

I_____, certify that the above information is correct. I understand that completing this application does not guarantee I will be eligible for Anderson Free Clinic services. **I understand that providing false or incomplete information, or failing to notify the clinic of change in household income or insurance status may result in my dismissal from being a free clinic patient.**

X_____ _____

Patient Signature **Date**

SECTION 5: Patient Responsibilities:

Please initial next to the following, indicating that you have read, understand and agree to the following consequences should you fail to comply with the following responsibilities:

_____ Initials **BEHAVIOR:** Patients are expected to behave appropriately while on free clinic property or at any other Location associated with the free clinic. Engaging in any of the following **UNACCEPTABLE BEHAVIORS** will result in my **IMMEDIATE DISMISSAL** from the Anderson Free Clinic:

- Any act of Violence, rude and disruptive behavior, verbally threatening or intimidating staff, volunteers, or other free clinic patients
- Bringing weapons of any kind onto Anderson Free Clinic property
- Using or possessing illegal substances on Anderson Free Clinic property
- Discriminating against Staff/Volunteers/Others on the basis of Race, ethnicity, gender, national origin, religious affiliation, or sexual orientation
- Damaging, littering or showing disrespect to, or smoking on AFC property

The following actions may result in temporary suspension or permanent dismissal from AFC:

- Using profanity, yelling, or otherwise exhibiting rude/disruptive behavior
- Failing to adhere to the agreed-upon treatment plan or providing false information about previous medical care
- Arriving intoxicated or under the influence of an illegal substance(s) on Free Clinic property
- Attempting to contact our Volunteer Physicians or referral doctors at their private practices or outside the context of the Free Clinic
- **Requesting prescriptions for controlled substances**
- **Asking AFC providers to fill out Disability forms or other paperwork certifying medical conditions**
- Engaging in disruptive or disrespectful behavior during a referral appointment or otherwise violating the Free Clinic Physician Referral Policy
- Failing to recertify with the Intake Coordinator on an annual basis or as requested

_____ Initials **PHARMACY**: Pharmacy hours are Tues-Fri 9am-1pm. Failure to meet the following guidelines may result in temporary or permanent lack of access to medications:

- Meet all deadlines to sign paperwork or turn in financial/insurance documents requested by the Patient Assistance Program Coordinator and required by pharmaceutical companies
- Failure to give our staff your most current phone and contact information
- Medications and refills take 2 BUSINESS days to be processed. Patients are responsible for requesting their medications accordingly
- Pharmacy will not give medications without a valid prescription. If out of refills, the patient MUST be seen by an AFC medical provider for a prescription to be written and filled
- Refills are written at provider discretion and may be subject to requested labs and tests

_____ Initials **FEES:** I understand that I am responsible for any bills associated with Labs/Radiology performed at AnMED that go beyond $1500. It is my responsibility to be aware of all costs associated with outside services. Additionally, I am responsible for paying Free Clinic and Pharmacy fees, including the annual $15 recertification fee and the $2+ per medication charged by the pharmacy.

X_____ _____

Patient Signature **Date**

SECTION 6: NO-SHOW, LAB, and REFERRAL Policy Agreement

Anderson Free Clinic NO-SHOW Policy:

It is expected that all patients arrive on time for appointments and come prepared with their medications in hand and must have any labs done at least 2 weeks prior to the appointment date**.**

MY APPOINTMENT WILL BE CANCELLED AND COUNTED AS A NO-SHOW IF:

1. If I fail to show up for an appointment without cancelling at least 24 hours in advance. TO CANCEL: leave a voicemail at 864-512-7804 with your name, date of birth, and a brief message.
2. If I arrive more than 15 minutes late for any appointment
3. If I show up for any appointment without all of my medications in original bottles
4. If I fail to complete lab tests at least two weeks before my scheduled appointment
5. IF I show up for an appointment INTOXICATED/Under the influence of Alcohol or Illegal substances, I will be NO-SHOWED for the appointment, and **given a formal warning of dismissal.**

NO SHOW CONSEQUENCES:

1. **The FIRST NO-SHOW:** is noted on the patient's chart
2. **The SECOND NO-SHOW:** within a twelve-month period will result in **SUSPENSION** of medical appointment privileges for one year from the date of the second no- show. Patients can attempt a walk in visit, with **no guarantee** that a provider has an opening.
3. **ANY ADDITIONAL NO-SHOWS** after the suspension period is over may result in TEMPORARY OR PERMANENT DISMISSAL from the Free Clinic

DENTAL APPOINTMENT NO-SHOW: All patients who NO-SHOW **ONE** dental appointment will NOT be eligible to return for dental care until 12 months after the date of the missed appointment.

X_____ _____

Patient Signature **Date**

Anderson Free Clinic Physician/Dentist Referral Policy:

1. Appointments will be made by the Free Clinic staff and you will be notified of the date and time
2. We CANNOT guarantee an appointment. Some physicians volunteer their time at their own practices to help Free Clinic patients who need care from a specialist, as per our referrals.
3. Medications prescribed by the referral provider can be filled at the Free Clinic pharmacy if we carry that medication or can obtain it. **If not**, it is the patient's responsibility to obtain the medication.
4. You MUST have your certification current at the Free Clinic to be eligible for a referral visit.
5. You must be seen first by a primary care physician and given a referral form which you must present at the time of your referral appointment in order to be seen
6. All free clinic policy regarding behavior and actions that are grounds for dismissal apply at any referral appointment or facility where labs are completed
7. It is YOUR responsibility to call the referral doctor's office if you need to cancel or reschedule an appointment. Appointments missed without YOU notifying the doctor's office may NOT be rescheduled and is counted as a NO-SHOW (see no-show policy above) .
8. It is the decision of each individual referral provider whether there will be any cost for the appointment. We will do our best to make you aware of any cost, but it is YOUR responsibility to verify that with the referral doctor's office.
9. Please be aware that any procedures or surgery done outside of the free clinic will be YOUR responsibility. Patients may call the AnMed Business office to determine if they qualify for their AnMed Medical Assistance Program also known as AMAP.

X_____ _____

Patient Signature **Date**

SECTION 7: Rights I am Forfeiting and Consent for Care

I understand that by receiving free care, I waive my right to take legal action against any and all medical and dental providers or ancillary personnel at this clinic or to otherwise seek a monetary recovery from Anderson Free Clinic and/or its employees and health care volunteers for any alleged professional acts of negligence, except for acts or omissions that are deemed to be grossly negligent or are considered willful and malicious, regardless of where such services are performed.

X_____ _____

Patient Signature **Date**

I am asking for care at this facility. I agree to receive medical services voluntarily and without compensation, expectation, or promise thereof; these medical services will be rendered by medical providers volunteering their service associated with Anderson Free Clinic. I agree to permit the medical provider and other caregivers associated with Anderson Free Clinic to treat me in ways they judge beneficial to me. I understand that this care may include tests, examinations, medical and/or surgical treatment. No one has given me any guarantee of how these examinations and treatment will affect my condition or me. This acknowledgement or agreement has been made prior to the rendering of medical services by the medical provider.

X_____ _____

Patient Signature **Date**

SECTION 8: HIPPA Authorization Release of Information

RELEASE AND RETREIVAL OF INFORMATION TO PHARMACEUTICAL, AGENCIES, INDIGENT CARE PROGRAMS, AND VARIOUS REFERRAL PROVIDERS:

To expedite the request of medication in a time efficient manner, I authorize the Free Clinic to provide my financial information (size of household, income, social security number, etc.) to prescription manufacturer and I give limited power of attorney to the Anderson Free Clinic to assign a staff to sign on my behalf on these forms and provide such companies. I authorize the Anderson Free Clinic to share biographical information, including facts related to my health, and financial information with other agencies, pharmaceutical companies and various referral physicians to better find and secure the appropriate care and/or treatment

I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO PROVIDE ANY INFORMATION UPON REQUEST, BUT IN SO DOING I UNDERSTAND THAT THIS MAY ALSO LIMIT THE RESOURCES/SERVICES AVAILABLE TO ME.

X_____ _____

Patient Signature **Date**

MEDICAL INFORMATION RELEASE TO INDIVIDUALS REGARDING MY HEALTH

Upon signature below I: *(Choose one by checking below)*

☐ **AUTHORIZE AFC** to leave messages or speak with the following person(s) regarding appointments, diagnosis, records, and/or examination rendered to me while I am an established patient of the Free Clinic:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ **DO NOT AUTHORIZE AFC** to speak with anyone else regarding appointments, diagnosis, records, and/or examination rendered to me while I am an established patient of the free clinic.

X_____ _____

Patient Signature **Date**

NO INCOME FORM

-This form is only to be used if there is NO household income-

Patient Section

I, _____ declare that I and no one living in my household have any income,
(patient's printed name)
including but not limited to wages, payment for odd jobs/cash payment, pensions, or other income. If I or anyone in my household receive assistance from SNAP (Food Stamps) and or the Housing Authority (HUD), I have attached proof of the amounts I receive from these assistance programs.

X_____ _____

Patient Signature **Date**

****Supporter Section****

Name: _____ Phone number: _____

What is your relation to the Patient? : _____

Do you live in a residence with the above signed patient? (circle) YES NO

If YES, how long has the patient lived in the same residence with you? _____

If AFC determines that this person is part of the patient's household they must also provide proof of their income.

I, _____ support the above mentioned person with the following monthly
(name of person helping patient)
amounts (if the answer is $0 for any of the following please state why and how the patient is able to pay for these):

$_____ Food (if $0 state why/how): _____

$_____ House/Rent (if $0 state why/how):_____

$_____Utilities (if $0 state why/how): _____

$_____Medication (if $0 state why/how):_____

$_____Transportation (If $0 state why/how):_____

Total: $_____

By signing below, I verify the above patient's current living situation and that ALL the above information is true.

X_____ _____

Supporter Signature **Date**

Anderson Free Clinic

Phone 864-512-7800
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: _____