HEALTHREACH
Community Clinic

Applicant
Name: _____Date:_____
(Please Print)

For New Patients and existing Patients being recertified:

Please be sure to include the following information with your application. Bring original of each document. Failure to bring documentation will delay the application process and treatment.

_____ Picture identification for applicant (NC or other state DMV issued ID or license/country of origin ID/passport)
_____ Copy of pages 1 and 2 of Current Tax Return (1040 or 1040 EZ) (required for Prescription Medications) (include Schedule "C" if one was used)
_____ Proof of residency (signed copy of Lease Agreement showing address, or electric, or water bill)
_____Completed MedAssist Application

_____ Proof of income for **EVERY** member of household. Proof of income includes:

- One month's (within last 30days) consecutive paystubs or a letter from employer on company letterhead detailing rate of pay per hour and number of hours ***per week*** worked and how often paid (if paid in cash).
- For Self-Employment income, please provide complete bank statements for the last 3 consecutive month(s) and provide last years' tax return and Schedule "C".
- Food Stamps (acceptance letter showing monthly award)
- Child Support Payments (copy of decree)
- Social Security Income (copy of current year benefits awards letter) If Social Security Disability income is received, also need copy of **original** awards letter showing disability date
- Unemployment Benefits (copy of awards letter or printout of weekly payment)
- Workman's Compensation Benefits awards letter
- Housing Assistance Letter

_____ If your income is provided to you by another individual, you must submit a support letter (provided by HealthReach) completed and signed by that individual

Bring your completed paperwork to an Eligibility Screening Clinic, held Tuesday through Friday from 9:00 a.m. - 3:00 p.m. After it is determined that you qualify, you will be given an appointment.

NOTE: We do not prescribe narcotics

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Patient Eligibility Screening Form

Name: _____ Date: _____

Date of Birth: ____/____/_____ Soc Security Number: _____

Race: _____ Primary Language: ____ English ___ Spanish ___ Other

Street Addr: _____

Phone (Home) _____ (Cell/Other) _____

City: _____Zip: _____

How Many People Live In Your Household?

(Include yourself)

Adults: _____ Children < 18 Yrs Old: _____

How Long Have You Lived at This Address?

_____Years_____Months

List All People (Including Yourself) Living Full Time at This Same Street Address

Name	Race	Sex	Age	SSN	Relationship	Inc/Mth
1.						$
2.						$
3.						$
4.						$
5.						$
6.						$
7.						$

Client Statement and Release of Information

I do hereby certify that the information above is truthful and accurate to the best of my knowledge and ability. I understand that if I intentionally fail to disclose true and accurate information that services can be suspended or terminated as deemed appropriate by HealthReach Community Clinic. I understand that in the case of termination, I will not be able to apply for assistance in the future. I further understand that services are suspended or terminated at the sole discretion of HealthReach Community Clinic.

I also give permission for HealthReach Community Clinic to contact and verify information from other agencies and companies as it pertains to this application and the services HealthReach provides.

Signed: _____

Printed Name:_____

INSTRUCTIONS AND REQUIREMENTS FOR BECOMING A PATIENT OF HEALTHREACH COMMUNITY CLINIC:

1. You cannot have health insurance, Medicaid nor Medicare .
2. You must fill in all sections of the application packet and return the **completed** forms with **PROOF OF INCOME**.
3. You must present a valid picture ID.
4. We reserve the right to determine who will be eligible to become a patient. We also reserve the right to discharge patients who do not honor their appointments and/or comply with clinic policies. Common reasons for patient dismissal:
   a. Failure to show up for scheduled appointments. We require that patients call 2 hours prior to their appointment to cancel or reschedule.
   b. Seeking narcotic drugs
   c. Providing false information of **any kind** will be grounds for immediate dismissal

This clinic is a non-profit institution. The Doctors and Nurses are volunteers. HealthReach Community Clinic relies on donations from citizens of the community, local organizations and grants in order to serve our patients. We are not affiliated with any hospital or government agency. Our services are limited to basic health care.

HealthReach Community Clinic will do whatever we can to help, BUT, potential patients are not guaranteed nor entitled to specific services.

By signing this document you acknowledge that you understand the contents of this document and agree to comply with the Clinic's policies. You also acknowledge that all the information you supply is true.

Your information is kept confidential.

Applicant's signature _____ Date _____
Patient/Authorized representative*

I understand HealthReach Clinic operates on a limited availability basis. It is not possible for the volunteer physicians or staff to be available 24 hours a day, seven days a week. Should I ever need emergency medical care, I will dial 911 or go to the nearest emergency room. If I need non-emergency care when the clinic is closed, I will seek alternative health care options such as the local urgent care center.

Applicant's signature _____ Date _____
Patient/Authorized representative*
*If Authorized Representative, please indicate relationship to patient:
_____ Spouse _____ Parent _____ Other (Please specify) _____

HEALTHREACH Community Clinic

For Patient Having Living Expenses Provided for Them

If you are providing patient with support please complete this form stating the amount of money provided each month.

Please complete all blanks:

$_____House/Rent (If answer is $0 state why):_____

$_____Food (If answer is $0 state why):_____

$_____Utilities (If answer is $0 state why):_____

$_____Gasoline (If answer is $0 state why):_____

$_____Spending/Other Money(If answer is $0 state why):_____

$_____Total amount per month provided to patient

By my signature, I attest that all information provided is accurate.

Providers' Name (Please Print)_____

Providers' Daytime Phone Number _____Evening Phone Number_____

Providers' Signature_____Date_____

Patients Name (Please Print)_____

Patients Signature_____Date_____

Note: The person providing support must sign this statement. The patient must sign this statement. Completed form must accompany application.

LETTER OF SUPPORT*

Date: _____

I, _____ (name of person providing support), pay rent and utilities on

behalf of *or* for _____ (person being supported). I am not financially responsible for his/her bills nor able to buy his/her medications.

I provide room and board in the amount of $ _____ per month (dollar value of support).

_____ _____

Signature Printed Name

_____ _____

Address Phone Number

***IF MORE THAN ONE PERSON IS SUPPORTING YOU, YOU WILL NEED TO GET A LETTER OF SUPPORT FROM EACH ONE.**

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, wages, unemployment benefits, disability benefits, self-employment income, Social Security and retirement. I understand that it is my responsibility to report to HealthReach Community Clinic the start of any income within 10 days of its beginnings. IF YOU HAVE NO INCOME PLEASE TELL US HOW YOUR HOUSEHOLD BILLS ARE PAID. IF ANOTHER PERSON PAYS THE BILLS, PLEASE PROVIDE A SIGNED LETTER(S) OF SUPPORT.

By signing this document I am agreeing that all of the information is accurate to the best of my knowledge.

Name _____Signature _____ Date _____

By my signature, I attest that I and no individual in my household have any income. If I or any individual in my household receive Food Stamps or help from the Housing Authority (HUD), I have attached proof of amounts received from Food Stamps and/or the Housing Authority (HUD).

I am living off of my savings until:_____

Patient Name (Please Print):_____

Patient Signature_____Date:_____