MOORE
FREE & CHARITABLE
CLINIC
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New Patient Application

Criteria For Enrollment:

☐ Must be uninsured

☐ Must be a Moore County resident

☐ Must be at or below 200% of the poverty level (see table to right)

200% Poverty Table		
# in house	-	Income
1	-	$23,540
2	-	$31,860
3	-	$40,180
4	-	$48,500
5	-	$56,820
6	-	$65,140
7	-	$73,460
8	-	$81,780

If you meet these criteria, please fill out the attached application according to the instructions and make a screening appointment with the Moore Free Care Clinic enrollment office.

OFFICE USE ONLY: DO NOT WRITE IN THIS BOX

Eligible ☐ From: _____ Until: _____

Not Eligible ☐ Reason: _____

Interviewer Name: _____ Date: _____

2015-8

211 Trimble Plant Road Southern Pines, NC 28387 Phone: 910.246.5333 Fax: 910.246.5330

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MFCC Documentation Checklist

Participant Eligibility

Moore Free and Charitable Clinic has legal obligations about who is eligible for care. It is important to read and understand the eligibility requirements and to also ensure that you bring the appropriate documentation to your Enrollment Appointment.

To recertify or become a new patient of MFCC you **MUST**:

- Make an appointment with the enrollment department
- Bring in ALL of the following documents

Please DO NOT mail any documents to the clinic, many times documents get lost in the mail.

If you have any questions or concerns, or need to schedule an appointment, call **(910)246-5333 ext. 259 or ext. 234**

Please bring *all* of the following to your appointment:

1. ☐ **Completed Enrollment Packet**

2. ☐ **Most recent (signed) Federal Tax Return**
   a. If you DID NOT file taxes, please fill out form 4506T (pg.6); **or**
   b. If someone has claimed you as a dependent, you will need to bring *their* tax return; **or**
   c. If your spouse filed taxes, you will need to bring *their* tax return; **or**
   d. If you were self-employed at any time in the last year you will need a *Schedule C*

3. ☐ **Copy of Photo ID**
   a. Driver's License; **or**
   b. State Issued ID; **or**
   c. Government Issued ID (this will NOT serve as Proof of Address).

4. ☐ **Proof of Address**
   a. Utility Bill (electric, gas, phone etc.) showing "service address";* **or**
   b. County Tax Bill; **or**
   c. Rental contract

   **Even if you do not pay the bills, we must have a copy of a bill for the address where you live and a statement on the "Letter of Support" (pg.5) from the person who pays for it.*

5. ☐ **Income Verification***
   Examples:
   a. Paycheck stubs;
   b. Benefits;
   c. Letter of Support (pg.5) from anyone supporting you

   **Please see next page for instructions on income verification*

★ **IMPORTANT NOTE:** Many medications in our Pharmacy Assistance Program **NOW REQUIRE** a Medicaid Denial letter. Should that become necessary, it is **YOUR** responsibility to furnish it in a timely manner in order to receive your medicine. ★

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Patient Information Sheet

☐ New Enrollment / Certification
☐ Re-Certification

Date: _____
Chart #: _____

Name (Print): _____
Date of Birth: _____
Social Security #: _____
Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email

Home Phone: _____
Cell Phone: _____
Email Address: _____
Would you like to receive text alerts? ☐ Yes ☐ No

Physical Address: _____
Mailing Address: _____

List all people who live with you in your household. Include full name and date of birth.

Name	Date of Birth	Relationship	Employment Status
1.			
2.			
3.			
4.			
5.			

Emergency Contact:
Name (Print): _____ Phone Number: _____
Relationship to you: _____

Current healthcare needs: _____

Do you have health insurance? ☐ Yes ☐ No
If yes, which of the following: ☐ Medicare ☐ Medicaid ☐ Family Planning ☐ Other_____

How did you hear about the clinic?
☐ Hospital ☐ ER ☐ DSS ☐ Case Manager ☐ Patient ☐ Other_____

Marital Status:
☐Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Ethnicity:
☐ Caucasian ☐ African American ☐ Hispanic ☐ Native American ☐ Asian ☐ Other_____

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Income Verification Worksheet

Are you currently employed? ☐ Yes ☐ No (NOTE: Please consider all work, including part-time or "side" jobs.)

Name of Employer: _____

How much do you earn per hour: _____ How many hours do you work per week: _____

Is your spouse employed? ☐ Yes ☐ No

Name of Employer: _____

How much do they earn per hour: _____ How many hours do they work per week: _____

Please estimate monthly income amounts for any of the following that apply to you or your spouse:

Employment Income:	$	Did you file current taxes?	☐ Yes ☐ No
Unemployment Income:	$	When did you last file?	
		Has anyone claimed you?	☐ Yes ☐ No
Pension/Retirement:	$	Who claimed you?	
Social Security:	$		
Disability:	$	Notes:	
VA Benefits:	$		
Other:	$		
TOTAL MONTHLY INCOME:	$		

Patient Signature: X _____ ***Date:*** _____

I hereby state that I have NO income.
Patient Signature: _____ ***Date:*** _____

ACKNOWLEDGEMENT:

I authorize the Moore Free Care Clinic to contact the Department of Social Services, Employment Security Commission, or any other agency or source for the specific purpose of obtaining and confirming information pertinent to my request for assistance from time to time. I further understand that everything in this interview and in the future will be kept in confidence except as stated above. Your signature confirms the information you have provided to be true and correct to the best of your knowledge. Information provided will be confirmed.

Patient Signature: X _____ ***Date:*** _____

I have not enrolled in the Affordable Care Act (ACA)
Patient Signature: X _____ ***Date:*** _____

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Income Verification Documents

Based on the information you provided on the previous page, identify which of the following best describes your situation and bring all of the listed documents to your certification appointment.

1. If you are **EMPLOYED**:
   - 30 days of *your* most recent paycheck stubs*
   - If you are paid cash, or paid irregularly:
     i. Signed statement by someone who has paid you for work in the past 30 days.

2. If your spouse is **EMPLOYED**:
   - 30 days of *their* most recent paycheck stubs*

   *ex: if paid monthly, bring 1 paycheck stub
   if paid twice per month, bring 3 paycheck stubs
   if paid weekly, bring 5 paycheck stubs

3. If you are **UNEMPLOYED** and have $0 income:
   - Fill out "Letter of Support" on pg.5 for anyone who is supporting you financially

4. If you are **UNEMPLOYED** but your spouse *IS* employed:
   - 30 days of *their* most recent paycheck stubs

5. If you or your spouse receive any **BENEFITS**:
   a. Bring *all* of the following that apply:*
      - Retirement
      - Disability
      - Unemployment
      - Supplemental Security Income

      *Must be in the form of a letter of award from the agency, examples of what these letters look like can be provided by the MFCC office.

If you have any questions about these materials, please call the clinic before your appointment at **(910) 246-5333 ext. 259 or ext. 234.**

Note: If you are a current patient, your recertification date with the Moore Free Care Clinic and with various Patient Assistance medication programs may not be the same. In this case, we may have to contact you in the future for more current documents.

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Letter of Support

If anyone is helping to support you financially, or giving you a place to live, please have them complete this page. This is for documentation only, we will never ask them to be responsible for your medical costs or give their information to a third party.

I am providing support for _____ in the following fashion:
(Print Patient's Name)

Check only one of the three boxes below:

- ☐ Lives with me at the address below and receives free room and board.
- ☐ Lives with me and shares expenses. My contribution to expenses is indicated below.
- ☐ Does not live with me but I provide support as indicated below.

I provide cash and other funding in the approximate amounts indicated below.

Please enter an approximate dollar amount for each item and check whether this amount is provided weekly or monthly. If you do not provide cash or other funding for a particular item, enter ($0).

Food:	$_____	☐ Weekly	☐ Monthly
Housing	$_____	☐ Weekly	☐ Monthly
Utilities	$_____	☐ Weekly	☐ Monthly
Cash	$_____	☐ Weekly	☐ Monthly
Other: (explain below)	$_____	☐ Weekly	☐ Monthly

Other support: _____.

Supporter's Name (Print): _____ Contact Number: _____

Physical Address: _____

Supporter's Name (Sign): _____ Date: _____

The above mentioned individual has, to the best of our knowledge, limited to zero ($0) income and is supported as stated above. The patient has met all certification requirements and is active and enrolled in the Moore Free Care Clinic.

Richard Lewis
Enrollment Coordinator

Courtney Harms
Enrollment & Patient Assistance Coordinator

Form **4506-T**
(Rev. September 2015)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☑

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / 31 / 2014	12 / 31 / 2015	/ /	/ /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** For transcripts being sent to a third party, this form must be received within 120 days of the signature date.

☑ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ Date
Signature (see instructions)

▶ _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ Date
Spouse's signature

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MFCC Patient Contract

1. **Cost:** The Moore Free and Charitable Clinic (MFCC) cares for many patients through the use of volunteer medical providers, as well as paid providers for both primary and specialty care. Although we have a small paid staff, many other persons donate their time to serve you without payment of any kind. We hope that you, as one of our patients, will understand that this is the reason we are able to provide reduced cost medical care for you, and we encourage you to express appreciation for this service to our physicians, staff and volunteers. The cost(s) that you may experience at this clinic is payment for prescription medications, transportation, the fee if you fail to show up for an appointment and do not cancel in advance, and a small copay. Also, some patients may require specialty care that is not available locally, and may require payment and/or application to other charity care programs, such as UNC specialty clinics. *We welcome our patients to make a small donation of money to the clinic as you are able.*

2. **Clinic hours:** Mon, Wed and Thurs: 8:30am – 4:30 pm
   Tues: 8:30am – 7 pm
   Fri: 9 am – 3 pm.
   The clinic is closed daily from 12:00 pm – 1:15 pm.

   Medication pick-up: is available during regular clinic hours from 9 am – 4 pm Monday through Thursday, and 9 am – 12 pm on Friday.

3. **Responsibility:** You are a vital part of the health care plan that will be put in place to help you achieve wellness; therefore, ***you are expected to be an active participant in your own care***. This means you are responsible for arriving to your appointments on time, taking medicines prescribed to you, and notifying the clinic if there are any changes in your health.

   If you need medication refills from your local pharmacy, you must contact them 5-7 days before you run out, so they can send us a medication refill request. If you receive medications through Patient Assistance Programs, you must contact us 30 days before you run out so that we may send the refill request to the company.

4. **Policies:** All of the following are taken seriously and have serious consequences if not followed:
   a. Financial documents: may be requested for enrollment with the clinic or patient assistance programs. If we do not get them in a timely manner, you will NOT be eligible for services.
   b. No-show Policy: If you are **15 minutes** late (or more) to your appointment, you will NOT be seen and will have to reschedule. Appointment slots are limited, patients that miss their appointments prevent other patients from being seen at the clinic.
      i. First no-show for ANY appointment: **$10 fee**
      ii. Second no-show: **Discharge from the clinic for 1 year**, after which you may re-apply to be a patient of the clinic.
   c. Appointment Cancellations: Call *at least **48 hours** before* your appointment time to cancel and reschedule. A late cancellation is considered a no-show and the no show policy will apply.
      Considerations will be made in case of emergency.
   d. Appointment reminders: You will be called or texted with an appointment reminder. It is your responsibility to provide the clinic with your updated contact information as soon as possible.

5. **Behavior:** Patients should understand that services provided at the clinic are free and negative attitudes toward any MFCC physician, nurse, staff, or volunteer will be grounds for immediate discharge from the clinic. **The clinic will NOT tolerate inappropriate conduct including rude, disruptive, or dishonest behavior.** Also, *misuse or "taking advantage of" the services provided by the clinic is considered inappropriate behavior* and grounds for discharge.

6. **Children:** Unfortunately, we do not offer medical services for children. Please avoid bringing children to your appointments. If you have no other option but to bring a child with you, you must also bring a responsible adult to watch them during the office visit. **Children are NOT permitted into the exam rooms** and must remain in the lobby under supervision.

The patient acknowledges the above expectations and agrees to the following:

- **I agree to keep appointments** for labs, X-rays and specialty referrals and I understand that if I miss my appointment without at least 48 hours' notice (excluding documented emergency), then I will be charged a fee or may be discharged from the clinic.

- I acknowledge that the Moore Free Care Clinic is a not-for-profit clinic staffed with medical providers as regularly as possible. MFCC seeks to provide patients with quality health care, but **patients are not guaranteed nor are they entitled to specific services.**

- I agree that if I do not provide **documents for eligibility screening or recertification** as required, then I will *not* be given an appointment and could be discharged from the clinic for one year and will have to reapply for admission as MFCC patient.

- I understand that the medications provided by MFCC may not be in childproof containers. I agree to keep all **medications out of reach of children**.
- **I agree to call the clinic at least 30 days before running out of medication to request a refill**. I also understand the MFCC often prescribes generic medications which are available at my local pharmacy at a very low cost, and that **I am responsible for purchasing my medications and requesting a refill 5-7 days in advance of running out** as part of my commitment to self-care.
- I give consent to MFCC **to have my medical records sent to physicians** for referral purposes or Moore Regional Hospital for treatment purposes.
- I understand that ***rude, threatening behavior*** *or* ***being under the influence*** *of alcohol, drugs or other substances may result in* ***termination*** of all MFCC services.
- ***I agree that if at any time I begin to receive Medicaid, Medicare, and any other insurance coverage or if I have a change in household income, I will immediately notify the clinic.***

IF I DO NOT UNDERSTAND ANY PART OF THIS CONTRACT I WILL ASK FOR CLARIFICATION.

ACKNOWLEDGEMENT

Patient Name: _____ Date: _____

Print

I agree that I have read and understand the MFCC Application and Patient Contract and accept the terms.

Signature: **X**_____ Date: _____

I agree that I have received a copy of the Notice of Privacy Practices (HIPAA) found on the following page.

Signature: **X**_____ Date: _____

Client Authorization to Release and Share Information

Client Information

This authorization is for the release and sharing of your individual identifiable information which includes: participation in any Network Agency program, demographic information to include name, birth date, gender, race, social security number, address, phone number, family members, financial information, employment status, residential, health and treatment history, and/or personal or family needs information.

Client's Name:		
Address:		
Birthdate:	**Phone Number:**	**Social Security #:**

Definition of Network Agency:

The Moore Free and Charitable Clinic is supported by a network of providers in the First Health network and the Moore County area. These agencies (collectively the "Network Agencies" or individual "Network Agency") at times need to share client protected information to better serve clients, reducing duplication of efforts and services among various social service agencies and healthcare providers, and to decrease gaps in access to services such as healthcare and medication for low-income people in Moore County.

Purpose of Release and Sharing of Information

The purpose of this Authorization Form is to allow staff of the Moore Free Care Clinic and First Health network of providers to better meet your needs through coordinated service identification, planning, and delivery.

Protection of Information to Be Shared:

We protect the information in our database by strictly limiting who can enter and read the information. We require all Network Agencies and Network Agency authorized staff members to sign confidentiality agreements to maintain the security of your information.

Authorization to Release and Share Information:

I hereby give my consent for my information to be entered into the Athena electronic database and shared with Network Agencies to be used for my care coordination, treatment and service delivery evaluation. A list of Network Agencies is available to me upon my request. My information will remain confidential and will not be used for marketing or solicitation purposes – or shared with any individuals or agencies outside of the Moore Free and Charitable Clinic and First Health – without written authorization from me. I understand that I can refuse access to part or all of my information, and may limit access to certain Network Agencies, at any time, by a written statement. If I choose not to give my consent, my refusal will not prevent me from receiving healthcare services from the Moore Free and Charitable Clinic. The Moore Free and Charitable Clinic reserves the right to add agencies from time to time to provide me with more opportunities for assistance. I hereby authorize the release and sharing of my individually identifiable information.

Release From Liability:

I hereby release the Moore Free and Charitable Clinic and ALL other Network Agencies that participate now or in the future, from any and all legal liability that may arise from the disclosure of my information.

Alcohol/Drug/Infectious Disease/Mental Health Records:

These records are protected by Federal Regulation 42CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. I UNDERSTAND that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse.

MFCC requires that information regarding sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), human immunodeficiency syndrome (HIV) infection, and mental health or substance abuse information be shared in order to provide you with quality of care. If I do not with this information to be shared, you will be unable to participate in the network.

Signature:	**Date:**

Agency Restriction:

I understand that restricting release and sharing of my information may limit the ability of the Network Agencies to provide care coordination and treatment for me or any minors for which I am responsible. If I do not wish my medical information to be shared with an individual provider/agency, I must notify my primary care provider.

Right to Revoke Authorization:

I may revoke this authorization at any time, in writing, before the information has been released. I further understand that I have a right to receive a copy of this authorization upon request.

Signature:	**Date:**