COMMUNITY CARE CLINIC of Rowan County, Inc.

ELIGIBILITY REQUIREMENTS & DIRECTIONS FOR APPLICATION

ELIGIBILITY REQUIREMENTS:

- Patients must be uninsured.
- Patients must be a Rowan County resident.
- Patients cannot have a household income exceeding 200% of the Federal Poverty Level (currently $23,760 for individual and $48,600 for a family of four).

DIRECTIONS FOR APPLICATION:

- Complete the Application For Services and Patient Health History Form. If you are self-employed, you must also complete the Self-Employed Statement of Income Form. These forms can be returned at any time the clinic is open. Incomplete application forms may cause a delay in services. This Eligibility Requirements & Directions For Application Form explains the items to bring to the Enrollment Appointment for verification of eligibility.

- Your application will be reviewed by the clinic staff. Please be sure that you have given a current phone number at which you can be contacted. You should expect to hear from the clinic within 14 business days of completing your application. If you are approved, you will be scheduled for an Enrollment Appointment. During the Enrollment Appointment, you will not see a doctor.

- The following information must be brought to the Enrollment Appointment. Copies of the information below will be made and you will complete any other forms needed for your chart. Your paperwork will be processed and you will be enrolled as a patient. Upon completion, your first doctor's appointment will be scheduled.

Proof of income for patient Pay stubs for the last three months, verification from ESC for unemployment, monthly pension statement, letter from social security showing monthly benefit for retirement or SSI for dependent, child support, etc. **Bank statement showing direct deposit cannot be used for proof of income**. If you are applying for disability, we will need a letter of verification of claim from the Social Security Administration or letter from your lawyer.

Proof of income for other household members Pay stubs for the last three months, verification from ESC for unemployment, monthly pension statement, letter from social security showing monthly benefit for retirement or SSI for dependent, child support, etc. **Bank statement showing direct deposit cannot be used for proof of income.**

Income tax return or 4506-T form If you filed taxes for the most recent tax year, we need either a copy of the 1040 or a transcript of you return. A transcript can be requested by calling 1-800-908-9946 or on-line at IRS.gov. If you did not file taxes, you will need to complete the attached 4506-T form.

Proof of Identification You will need a valid North Carolina driver's license or state identification card with a Rowan County address. You will also need to bring your social security card or a letter from the Social Security Administration with verified social security number.

Medicaid denial OR written statement from Social Services (Letter of Inquiry) stating you are not eligible for Medicaid less than 6 months old. If Social Services denies your Medicaid because you have not given them the information they requested, you must go back and complete the application before eligibility can be approved. If you have applied for Medicaid, but have not received an answer, we need proof of an application. We have included a letter that you can take with you to Social Services to apply for Medicaid.

Beginning January 1, 2018, the clinic will ask for a $10.00 non-refundable administrative fee per quarter. Patients can pay the $40 for the year or $10 per quarter. Patients who do not comply will be locked out and can unlock for $10 (maximum one time per year).

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Please take this letter with you to the Department of Social Services in case there are questions regarding the paperwork you are requesting.

To Whom It May Concern:

In order to provide medications at no cost to patients at the Community Care Clinic, drug companies require documentation that the patient has either applied for, OR is not eligible for Medicaid. A letter of inquiry is acceptable if it states the patient does not meet guidelines to receive Medicaid benefits. We do encourage patients to apply only if they feel they may be eligible for benefits. If the patient does apply for benefits and is denied, we need a copy of the denial letter within 90 days of the initial visit to the clinic.

The Department of Social Services has requested that our patients provide the following information: two proofs of residency (utility bill, driver's license) and proof of income (paycheck stubs – one month prior) to expedite this process.

If you need any further information, or have questions regarding required documentation, please feel free to contact me at 704-636-4523 ext. 201.

Sincerely,

Deborah Bailey

Front Desk/Receptionist

COMMUNITY CARE CLINIC of Rowan County, Inc.

Office Use Only
Date submitted _____
1st Contact _____
2nd Contact _____
Enrollment Appt. _____

APPLICATION FOR SERVICES

Date: _____/_____/_____ Sex: ☐ M ☐ F Race: _____ Age: _____ Date of Birth: _____/_____/_____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with significant other

Name: _____ SS# _____-_____-_____
Last First Middle Maiden

Are you a US citizen? ☐ Yes ☐ No Are you a legal resident? ☐ Yes ☐ No Are you a Rowan County resident? ☐ Yes ☐ No

Does the PATIENT speak English? ☐Yes ☐ No (If you answered no, it is unlikely that the clinic can provide services.)

Street Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

Best Contact Number _____

Next of Kin / Emergency Contact Name _____ Relationship _____

Emergency Contact Phone Number _____

How did you hear about the clinic? _____

Are you employed? ☐ Yes ☐ No Employer Name _____

Did you file taxes? ☐ Yes ☐ No Are you claimed as a dependent on someone else's taxes? ☐Yes ☐ No

Are you filing for disability? ☐ Yes ☐ No

Are you a veteran? ☐ Yes ☐ No

Do you have any of the following?

Medicaid	☐ Yes	☐ No
Medicare	☐ Yes	☐ No
Medical insurance	☐ Yes	☐ No
Dental insurance	☐ Yes	☐ No

Are you eligible for VA benefits?

Medical	☐ Yes	☐ No
Dental	☐ Yes	☐ No
Prescription	☐ Yes	☐ No

LIST TOTAL MONTHLY HOUSEHOLD INCOME AMOUNTS

Salary/wages	_____	Disability	_____
Social Security	_____	Worker's Comp	_____
Unemployment	_____	Self Employment	_____
Pension	_____	Other	_____

Number of adults in household: _____

Number of children in household: _____

Office Use Only

ID	___
SS Card	___
Income	___
Taxes/4506-T form	___
Disability App	___
Medicaid Denial	___
Admin Fee	___

SERVICES REQUESTED

_____I need to see a doctor at this clinic.

_____I need to see a dentist at this clinic. Reason for needing to see a dentist:

☐ Toothache ☐ Cavities ☐Extraction ☐ Broken tooth ☐ Cleaning

The dental clinic does not provide dentures, partials, crowns, root canals or oral surgery.

If applying for medical ***and*** dental services, what is your ***immediate*** need? Medical or Dental (Circle one)

NOTE: The Community Care Clinic does not provide pain management or surgical services. If you need treatment for depression or mental health issues, contact Daymark Recovery Services at 704-633-3616. **We do not prescribe narcotics or controlled medications.** If these are your medical needs, it is highly unlikely that the Community Care Clinic will be able to serve you.

Applicant Signature _____ Date _____

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PATIENT HEALTH HISTORY FORM

Name: _____ **Date:** _____
(Please Print)
Height _____ **Weight**_____

I Need Treatment For:

- ☐ Diabetes — Last blood sugar reading: _____
- ☐ High blood pressure — Last blood pressure reading: _____
- ☐ Heart problems ☐ Thyroid ☐ Cholesterol
- ☐ Other (Please list): _____

Other Health Conditions (Check all that apply):

___ Anemia	___Bronchitis	___Hearing loss	___Ulcers
___ Angina	___Cataracts	___Hepatitis (liver disease)	
___ Arthritis	___Cirrhosis of the liver	___Kidney problems	
___ Bladder infections	___Emphysema	___Seizures	
___ Blindness	___Headaches	___Tuberculosis	

Have you recently been in the hospital or visited the ER for any illness or injury? Yes ____ No___

Approximate Date	Place	Reason

Do you have a physician that you see regularly? Yes____ No_____
Physician Name and Phone Number _____
Do you have any food allergies? _____
Are you allergic to any medications that you know of? _____

What medications are you taking now, or should you be taking on a regular basis?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you currently being treated for depression or any other mental health disorder? Yes ___No ____

To best serve you, please answer to the best of your ability:

Do you smoke?	Yes ____	No ____	How much per day? _____
Do you drink alcohol?	Yes ____	No ____	How often? _____
Have you ever used street drugs?	Yes ____	No ____	What type? _____ Last used? _____
Have you ever shared needles?	Yes ____	No ____	
Do you have transportation?	Yes ____	No ____	What type? _____
Do you feel safe in your home?	Yes ____	No ____	

In the last year, have there been any major life changes (marriage, divorce, death of a loved one, illness or injury, financial struggles) that you would like to make us aware of?

_____

ALL INFORMATION DISCLOSED WILL BE KEPT CONFIDENTIAL