

***ELIGIBILITY REQUIREMENTS & DIRECTIONS FOR APPLICATION***

**ELIGIBILITY REQUIREMENTS:**

* Patients must be an uninsured adult and a Rowan County resident.
* Patients cannot have a household income exceeding 250% of the Federal Poverty Level (currently $25,520 for individual and $52,400 for a family of four). **Household income refers to the combined gross income of all members of a household, defined as a group of people living together, who are 15 years or older.**

***For Spanish speaking applicants:*** En este momento, no hay naconas personas en la clínica que puedan hablar español. Por eso, si estás aprobado por servicios, necesitarás traer tu propio traductor. Esto incluye todos las citas y todos los pasos del proceso de solicitud. Gracias por tu comprensión.

**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.
* **SERVICES:** It is the purpose of the Community Care Clinic of Rowan County to provide a high standard of care. The CCC is a primary care clinic and there will be limitations on services we can provide. The Board of Directors guides the clinic in the mission of providing the highest quality of patient care possible. The CCC does not offer services such as DOT physicals, disability evaluations, gynecology and/or pregnancy/STD testing.

**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** **Household income refers to the combined gross income of all members of a household, defined as a group of people living together, who are 15 years or older.**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** 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.

**Proof of Identification & Residency** ID - You will need a valid N.C. 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. Residency - You will need to provide one recent document providing residency in Rowan County. Accepted documents include utility bill (gas, water, electricity) and/or rental or lease agreement.

**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.

***The clinic requires 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 (max. one time per year).***



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. We request that all patients apply to determine if 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

Office Manager



**Office Use Only**

Date submitted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enrollment Appt. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***APPLICATION FOR SERVICES***

***(All forms must be completed before they will be reviewed for eligibility.)***

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 \_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Best Contact Number\*\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\*\*It is very important that we have a current phone number on file.***

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

**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

Are you filing for disability? □ Yes □ No

Are you a veteran? □ Yes □ No

**LIST TOTAL MONTHLY HOUSEHOLD INCOME AMOUNTS**

Salary/wages \_\_\_\_\_\_\_ Disability \_\_\_\_\_\_\_

Social Security \_\_\_\_\_\_\_ Worker’s Comp \_\_\_\_\_\_\_

Unemployment \_\_\_\_\_\_\_ Self Employment \_\_\_\_\_\_\_

Pension \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_

# of adults in HH: \_\_\_\_\_\_\_

Office Use Only

ID \_\_\_

SS Card \_\_\_

Income \_\_\_

Taxes \_\_\_

Disability App \_\_\_

Medicaid Denial \_\_\_

Admin Fee \_\_\_

Proof of Residency \_\_\_

# of children in HH: \_\_\_\_\_\_\_

**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 *(including Gabapentin).*** If these are your medical needs, it is highly unlikely that the Community Care Clinic will be able to serve you.

Applicant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



***PATIENT HEALTH HISTORY FORM***

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height**: **Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I Need Treatment For:**

\_\_\_ Diabetes Last blood sugar reading: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ High blood pressure Last blood pressure reading: \_\_\_\_\_\_\_\_\_\_

\_\_\_ Heart problems \_\_\_ Thyroid

\_\_\_ Hepatitis (liver disease) \_\_\_ Cholesterol

\_\_\_ Other (Please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Health Conditions (Check all that apply):**

\_\_\_ Anemia \_\_\_Bronchitis \_\_\_Hearing loss

\_\_\_ Angina \_\_\_Cataracts \_\_\_Ulcers

\_\_\_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 \_\_\_\_ Have you been tested for Hep C? \_\_\_\_\_\_\_\_\_

**Do you have transportation?**  Yes \_\_\_\_ No \_\_\_\_ What type? \_\_\_\_\_\_\_\_\_\_

**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**? ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Dental Health Patient History***

**Rate your pain** (Scale of 1 to 10). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When was last time you saw a dentist?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How often do you brush your teeth?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How often do you floss?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How often do you consume sugary drinks and how much?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALL INFORMATION DISCLOSED WILL BE KEPT CONFIDENTIAL**