Charlotte Community Health Clinic, Inc.

NEW PATIENT SLIDING FEE DISCOUNT PROGRAM APPLICATION

Charlotte Community Health Clinic is committed to providing quality health care to all members of the community regardless of their ability to pay.

All patients of Charlotte Community Health Clinic with household income at or below 200% of the Federal Poverty level and that provide required documentation will be eligible for medical, behavioral, dental, and prescription discounts.

Two pieces of information are required in order to qualify: the amount of money earned in the household and the number of people who live in the household. To be eligible for the Sliding Fee Scale, you must provide accurate and acceptable proof of income as well as list all persons within the household or you will be responsible for 100% of all charges.

PLEASE PROVIDE COPIES – WILL NOT BE RETURNED
(documents will be shredded for privacy after use)

Acceptable Proof of Income – Provide for each adult listed on application

- Most recent Federal Income Tax Return
- W-2 forms
- 30 days most recent pay stubs (more is better)
- Employer's Letter on letterhead (must include contact name and phone number)
- Agency letter: A letter from the Social Security Administration, Veterans Administration or Social Service Agency indicating income level.
- Unemployment Verification: Paperwork from the Employment Securities Commission (ESC) proving unemployment status and the amount of unemployment compensation being received.
- Alimony or Child Support Agreement
- Bank statement (only if it shows a direct deposit)
- Official Paperwork: Paperwork documenting retirement, disability, SSI benefits.
- If homeless: Letter from shelter where you are getting services
- If homeless/Doubling Up: Doubling up verification form
- If completely supported by a friend/relative, signed letter of support from that person

Identification Determination – Provide for each member of the household listed on the application

All members of household who are pooling financial resources including room and board and/or are supporting one another financially are counted as one household.

- Picture ID for all adult members of the household who are applying for assistance (license, passport, permanent resident card)
- Proper ID for all children (school ID, insurance card, social security card, birth certificate) for dependents under the age of 18.

Complete and sign the attached application and return along with required proof of income and identification to any of the below NO LATER THAN ONE WEEK BEFORE YOUR APPOINTMENT:
Via email to financial.docs@cchc-clt.org
In person to Charlotte Community Health Clinic, 8401 Medical Plaza Dr, Suite 300, Charlotte, NC 28262
In person to Charlotte Community Health Clinic, 5301 Wilkinson Blvd, Charlotte, NC 28208

CHARLOTTE COMMUNITY HEALTH CLINIC

Name: _____ **DOB:** _____ **MRN:** _____ **Date Received:** _____
(Office Use Only) (Office Use Only)

☐ **I have been given the opportunity to apply for the CCHC discount services sliding fee schedule, and I DO NOT WISH TO APPLY FOR THE CCHC DISCOUNT SERVICES SLIDING FEE PROGRAM AT THIS TIME.**

Patient Signature _____ Date _____

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical, behavioral health and/or dental needs. **This form will not be used to withhold or deny services to you.**

1. Is any other family member applying for a discount with this application? ☐ Yes ☐ No
   If yes, please indicate in final column below
2. Are you covered under Medicaid, Medicare or any other insurance? ☐ Yes ☐ No
3. If you have private insurance, what is your annual deductible, per family member? $_____
4. Have you or your dependents ever applied for and been denied Medicaid or Medicare? ☐ Yes ☐ No
5. Would you like assistance applying or re-applying for Medicaid? ☐ Yes ☐ No
6. Are you unemployed? ☐ Yes ☐ No
7. Are you too sick to work or are you disabled? ☐ Yes ☐ No

TO BE COMPLETED BY PATIENT/GUARDIAN: Please include yourself, your spouse /partner, children and everyone else living in the home

Name*	Relation in Family	Date of Birth	Income	Frequency	Proof of Income*	Health insurance plans by which you are covered	Annual Deductible	Applying for Assistance?
Example: John Doe	Self	5/16/46	$346	weekly	Tax Form	Medicare	None	Yes

***See attached list for acceptable forms for proof of income and household members**

I have attached proof of income for the amounts listed above ☐ Yes ☐ No
I have provided proof of and identification for household members listed above ☐ Yes ☐ No
<u>Documentation must be provided by patient or guardian to determine eligibility for Sliding Fee Scale</u>

I understand that the information I provide on this form is subject to verification by Charlotte Community Health Clinic. I certify that the above information is true and correct to the best of my knowledge and that I understand & agree that providing false information can result in me being denied ability to apply for the program; furthermore I agree to adhere to all terms and conditions of the Sliding Fee Discount Program. I will report any changes of the above information to CCHC. **I also understand that I must supply proof of income before my next visit, or I will have to pay the full price with no discount.**

_____ _____ _____
Patient/Guardian Signature Printed Name Date

CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
Chart #_____

PATIENT REGISTRATION FORM

Please PRINT. Please return completed form(s) to Registration.

☐ Medical ☐ Dental ☐ Behavioral Health

PATIENT INFORMATION

Full Name: _____ Referred By: _____
FIRST MI LAST

If patient is a minor: Parent/Legal Guardian Name _____

Date of birth: _____/_____/_____ **Social Security/W7** #: _____-_____-_____

Sex: ☐ Male ☐ Female ☐ Transgender Female/Male to Female ☐ Transgender Male/Female to Male ☐ Other

Street Address or PO Box: _____

City: _____ **State:** _____ **Zip Code** _____ **County:** _____

Email: _____ **Home Phone:** _____ **Work Phone:** _____

Emergency Contact: _____ **Telephone:** _____ **Relationship:** _____

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

Employed ☐Full Time ☐Part time ☐ Unemployed **Student** ☐Yes-Full Time ☐ Yes-Part time ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Other Country of Origin _____
Do you need an interpreter? ☐ YES ☐ NO

Ethnicity (check one) ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race (check one): ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black/African American ☐ White/Caucasian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other

Characteristics –Special Populations (data used by CCHC due to being a Federally Qualified Health Center which offers the sliding fee based on income and number of persons in household)

Are you a veteran? ☐ YES ☐ NO

Are you a farmworker? ☐ YES ☐ NO

Where do you live? ☐ Rent or Own Home/Apartment ☐ Public Housing ☐ Shelter ☐ Street/Car (Unable to Get Referral)
☐ Transitional (live place to place) ☐ Doubling Up (Unable to maintain housing) ☐ Other

Household Income Range: ☐ less than $11,500 ☐ $11,500-15,000 ☐ $15,001-20,000 ☐ $20,001-30,000 ☐ $30,001-40,000
☐ $40,001-50,000 ☐ $50,001-60,000 ☐ $60,001-$70,000 ☐ $70,001-80,000 ☐ $80,001-90,000
☐ more than $90,000

Number of persons in Household: Adults: _____ Children: _____

Sexual Orientation: ☐ Straight (not lesbian or gay) ☐ Lesbian or Gay ☐ Bisexual
☐ Something else ☐ Don't know ☐ Choose not to disclose

RESPONSIBLE PARTY INFORMATION (Who pays the bills?)

(Complete this section if Responsible Party is NOT the Patient)

Relationship of Responsible Party: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other _____

Name: _____ **Sex:** ☐ M ☐ F
FIRST MI LAST

Street Address or PO Box: _____

City: _____ **State:** _____ **Zip Code** _____

Home Phone: _____ **Work Phone** _____

Employer: _____ **Date of birth:** ____/____/____ **Social Security #:** _____-_____-_____

Date: _____
Chart#_____

INSURANCE INFORMATION

Please present your insurance card each time you check-in

PRIMARY INSURANCE

Plan Name: _____ **ID Number:** _____

Address: _____ **Group Number:** _____

Policy Holder: _____ **Effective Date:** _____

Policy Holder's Social Security No.: _____-_____-_____ **Sex:** ☐ M ☐ F

Policy Holder's Date of birth: _____/_____/_____

Employer: _____

SECONDARY INSURANCE

Plan Name: _____ **ID Number:** _____

Address: _____ **Group Number:** _____

Policy Holder: _____ **Effective Date:** _____

Policy Holder's Social Security No.: _____-_____-_____ **Sex:** ☐ M ☐ F

Policy Holder's Date of birth: _____/_____/_____

CCHC requires payment on the day of service. This payment includes outstanding deductibles, co-payments, non-covered services, sliding fee payments and any charges remaining after insurance has made payment on your account. Please be advised that your insurance may not cover all of your charges and that you are responsible for any balance on your account and will be billed until that balance is paid. The Sliding Fee Program is available for families with low incomes. This program allows patients to get a discount on their charges. You must apply with registration staff with documentation of total income and number of persons in the household. You must reapply for the program every year and payment must be made at time of service. Signing of this form indicates you are aware of above policies and procedures and were advised of the sliding fee program. I hereby authorize assignment of all insurance benefits payable directly to CCHC.

Signed: _____ **Date**: _____/_____/_____

Referrals/Option to Choose

CCHC is a primary care provider and is not equipped to provide all medical services that may be appropriate for your medical care. In some cases, CCHC may recommend that you receive additional medical services, such as laboratory services, imaging services or specialty care from another healthcare provider. In the event that this does occur, please be advised that you may be required to pay on the day of service and/or be billed for any balance on your account with the referral provider.

Signed: _____ **Date**: _____/_____/_____

Authorization for Release of Information

I authorize Charlotte Community Health Clinic to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for the purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify Charlotte Community Health Clinic in writing of any information I do not want released.

Signed: _____ **Date**: _____/_____/_____

Patient Acknowledgement

Receipt of Notice of Privacy Practices and Patient Rights and Responsibilities

I acknowledge that I have received and been given an opportunity to read a copy of the Charlotte Community Health Clinic's Notice of Privacy Practices and Patient Rights and Responsibilities.

Patient/Guardian Signature: _____ Date: _____

CHARLOTTE COMMUNITY HEALTH CLINIC

Date: _____
Chart #_____

Medical Information Release Form
(HIPAA Release Form)

Patient Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call

[ ] my home number _____

[ ] my work number _____

[ ] my cell Number _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signature of Patient (or Guardian): _____ Date: ____/____/_____

Signature of Witness:_____ Date: ___/____/_____

CHARLOTTE COMMUNITY HEALTH CLINIC

Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. Please answer all questions to the best of your ability.

Name: _____ Age_____

How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: _____

Other concerns: _____

Allergies or reactions to medications, foods, and animals: _____

Review of Systems: In the last **TWO WEEKS**, have you had any of the following (check all that apply)?

General Health	**Genitourinary**
_____ Recent fevers/sweats/chills	_____ Painful/bloody urination
_____ Unexplained fatigue/weakness	_____ Leaking urine
_____ Unexplained weight loss/gain	_____ Frequent urination
Eyes, Ears, Nose, Mouth, Throat	_____ Nighttime urination
_____ Change in vision	_____ Discharge (penis or vagina)
_____ Difficulty hearing/ringing in ears	_____ Testicular pain/swelling
_____ Hay fever/allergies	_____ Unusual vaginal bleeding
_____ Trouble swallowing	_____ Irregular menstrual periods
Respiratory	**Musculoskeletal**
_____ Coughing/wheezing	_____ Muscle/joint pain
_____ Coughing up blood	_____ Back pain (new onset)
Cardiovascular	_____ Back pain (chronic)
_____ Chest pain/discomfort	**Breast**
_____ Palpitations/irregular heartbeat	_____ Breast lump
_____ Shortness of breath with activity	_____ Nipple discharge
_____ Swelling in legs or feet	**Skin**
Gastrointestinal	_____ Skin rash or lesions
_____ Heartburn/reflux	_____ New mole or change in mole
_____ Blood in stools	**Neurological**
_____ Nausea/vomiting/diarrhea	_____ Headaches
_____ Change in bowel habits	_____ Memory loss
Endocrine	_____ Fainting
_____ Heat/cold intolerance	_____ Dizziness
_____ Dry skin	_____ Numbness/tingling
_____ Thinning hair	**Hematologic**
_____ Increase in thirst/appetite	_____ Unexplained lumps/swollen glands
	_____ Easy bruising/bleeding
	Emotional
	_____ Anxiety or stress
	_____ Trouble sleeping
	_____ Sadness or depression

CHARLOTTE COMMUNITY HEALTH CLINIC

Health History Form

MEDICATIONS:

Please list **all** prescription and non-prescription medicines you take, including vitamins, home remedies, birth control pills, herbs, etc. (You can also attach a separate medication list.)

Medication	Dose (e.g., mg/pill)	How many times per day?

PAST MEDICAL HISTORY:

Please tell us if you have had any of the following problems with year of diagnosis (if known).

Heart attack	_____	High blood pressure	_____
Stroke	_____	Diabetes	_____
Thyroid problems	_____	Seizures	_____
Stomach ulcer	_____	Kidney disease	_____
Asthma	_____	Cancer (what kind)	_____
COPD or Emphysema	_____	Hepatitis	_____
Mental Health Problem	_____	HIV/AIDS	_____
Blood disorder	_____	High cholesterol	_____
Other (specify)	_____		

SURGICAL HISTORY:

Please list all prior operations (with dates):

FAMILY HISTORY:

Please tell us if anyone in your family (mother/father, grandparents, siblings, and children) has any of these medical conditions. □ Unknown □ Adopted

Heart attack	_____	High blood pressure	_____
Stroke	_____	Diabetes	_____
Thyroid problems	_____	Seizures	_____
Stomach ulcer	_____	Kidney disease	_____
Asthma	_____	Cancer (what kind)	_____
COPD or Emphysema	_____	Hepatitis	_____
Mental Health Problem	_____	HIV/AIDS	_____
Blood disorder	_____	High cholesterol	_____
Other (specify)	_____		

Is your mother living?	YES	NO	Cause of death? _____
Is your father living?	YES	NO	Cause of death? _____

CHARLOTTE COMMUNITY HEALTH CLINIC

Health History Form

SOCIAL HISTORY

Tobacco/Nicotine Use

Have you ever smoked? YES NO When did you start smoking? _____
(If you quit) When did you stop smoking? _____

If currently smoking, how many packs per day do you smoke? _____
If you are currently smoking, are you interested in quitting? YES NO
If you have tried to quit before, what methods have you tried? _____

Do you vape/use E-cigarettes? YES NO When did you start vaping? _____
Are you interested in quitting? YES NO (If you quit) When did you stop vaping? _____

Alcohol Use

Do you drink alcohol? YES NO Number of beers per week _____
Are you concerned about your drinking? YES NO Number of glasses of wine per week _____
Have others told you that you drink too much? YES NO Number of liquor drinks per week _____

Drug Use

Are you currently using recreational drugs? YES NO If yes, which drug(s)? _____
Have you ever used recreational drugs? YES NO If yes, which drug(s)?_____
If yes, when did you stop? _____
Have you ever used needles to inject drugs? YES NO If yes, when was the last time? _____

Sexual History

Gender: ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Other
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Sexual Orientation: ☐ Straight (not lesbian or gay) ☐ Lesbian or Gay ☐ Bisexual
☐ Something else ☐ Questioning ☐ Choose not to disclose
How many sexual partners have you had in the last 12 months? _____
Do you have sex with MEN WOMEN BOTH
Do you use contraception/birth control (if so what kind)? _____
First Day of Last Menstrual Period (Date) _____

Safety

Do you have access to firearms or guns? YES NO
Do you ever feel unsafe at home or in your relationship with your partner/family/significant other? YES NO
Are you currently feeling sad or depressed? YES NO
Are you currently being treated for depression or other mental health issues? YES NO

Other

What is your highest level of education? _____
What is your occupation? _____
Who lives at home with you? _____
Are there any animals where you are living (specify)? _____
Have you ever served in the military? _____
Do you have any religious preference (specify)? _____
How many children do you have? _____

_____ _____

Patient Signature **Date**