Charlotte Community Health Clinic, Inc.

ESTABLISHED 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, 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.

PLEASE RETURN THE ATTACHED APPLICATION AND PROOF OF INCOME (see below list) TO CCHC PRIOR TO YOUR NEXT APPOINTMENT OR YOU WILL BE RESPONSIBLE FOR 100% OF ALL CHARGES AT THAT APPOINTMENT.

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

Complete and sign the attached application and return to CCHC, along with proof of income prior to your next 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

Charlotte Community Health Clinic, Inc.

ESTABLISHED PATIENT SLIDING FEE DISCOUNT PROGRAM APPLICATION

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

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. Are you unemployed? ☐ Yes ☐ No
5. 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
Documentation must be provided by patient or guardian to determine eligibility for Sliding Fee Scale

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.**

_____ _____

CHARLOTTE COMMUNITY HEALTH CLINIC

Patient Renewal Registration Form

MRN _____ **Date:** _____

Patient Name: _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: ___/___/___ **Social Security/ W7:** _____-_____-_____

Mailing Address Information

Address _____

City _____ State _____ Zip _____

Phone Number _____ (Please Select: Work/Cell/Home)

Alternate Phone # _____ (Please Select: Work/Cell/Home)

Email: _____

Emergency Contact: _____**Phone #:** _____
Relationship: _____

Sex ☐ Mal ☐ Female ☐ Transgender (Male to female) ☐ Transgender (Female to Male)

Sexual Orientation: ☐ Straight (not lesbian or Gay) ☐ Lesbian or Gay ☐ Bisexual ☐ something else ☐ don't know

□ Choose not to disclose

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

Employed: ☐ Full time ☐ Part time ☐ Unemployed ☐ Student Full time ☐ Student Part Time

Race (Please select all that apply)

☐ White/Caucasian ☐ Black/African American ☐ American Indian ☐ Asian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Alaskan Native ☐ Other: _____

Are you of Hispanic or Latino origin? ☐ Ye ☐ No
Country of Origen? _____
Are you a Veteran of one of the U.S. Armed Forces? ☐ Yes ☐ No

Are you covered under BCBS, UHC, AETNA, Cigna, Medicaid, Medicare, Bright Health or any other Health Insurance? ☐ Yes ☐ No

CHARLOTTE COMMUNITY HEALTH CLINIC

MRN: _____

(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

MRN: _____

Notice of Privacy Practices
Receipt & Acknowledgement of Notice

Patients Name: _____

Date of Birth: _____

Social Security #: _____

I hereby acknowledge that I have received and given an opportunity to read a copy of the Charlotte Community Health Clinic's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Administrative Office at 704-384-1980.

_____ _____

Patient Signature/Guardian/Personal Representative **Date**

_____ _____

Signature of Staff Member **Date**

Revised 08.30.18

Charlotte Community Health Clinic

Medical, Behavior Health and Dental Appointment Agreement

____ New Patients: Please arrive thirty (30) minutes early for patient registration.

____ Emergencies/Urgent:

Medical/BH: Patients are only allowed one (1) emergency/urgent appointment before the new patient appointment.

Dental: Patients are only allowed one (1) emergency appointment as a new patient. The next appointment will be for a comprehensive exam.

____ Sliding Fee Scale:

Dental: Proof of your card from CCHC is required at the first appointment. For patients that are not part of CCHC, you are required proof of insurance. If you don't have coverage you will be charge our full fee until income information is provide to us or you can be seen under our walk in policy. All documents need to be updated yearly.

Medical/BH: Proof of income or Insurance will be required at the first appointment. If you don't have coverage or proof of your income for the first visit you will be charge our full fee until income information is provide to us. All documents need to be updated yearly.

____ Late Arrival:

Medical/BH/Dental: If you arrive more than fifteen (15) minutes late for your appointment, you may be ask to reschedule or be worked in to a vacant appointment.

____ Cancellations:

Medical/BH/Dental: When cancelling an appointment, you must give at least twenty-four (24) hour' notice. When a patient misses an appointment, we miss the opportunity to care for the patient as well as another patient who could have used that appointment slot.

CHARLOTTE COMMUNITY HEALTH CLINIC

____ No Show:

Medical/BH/Dental: (1) If an appointment is missed completely, (2) when the patient is more than 15 minutes late by the clinic clock and has not called one full day (24 hrs.) ahead of the appointment to reschedule it's a No Show.* When a patient accumulates three (3) no show appointments consecutives in Medical or two (2) Broken appointment on Dental, that person will not be allowed to schedule ANY further routine/ follow up appointments for a period of six (6) month following the third consecutive no show in Medical or the second broken appointment on Dental. Example:

____ Medical/ BH

I. **First No Show**: A note will be placed in the chart and the patient will verbally reminded of our policy.
II. **Second No Show:** A note will be placed in the chart and the patient will verbally reminded again of our policy.
III. **Third No Show:** Patient will not be allowed to make appointments in advance for a period of six (6) months.

____ Dental

I. **First Missed Appointment:** A note will be placed in the chart and the patient will verbally reminded of our office policy.
II. **Second Missed Appointment:** The patient will not be allowed to schedule another appointment for six (6) months.
III. **Third Missed Appointment:** The patient will not be allowed to make advance appointments for a period of one (1) year, except for emergencies.

- **If a patient is schedule with another family member and the both fail to show for their appointments, the family will no longer be able to schedule multiple appointment on the same day.**

I understand and agree to abide by Charlotte Community Health Clinic Appointment Agreement

Patient/Parent Signature: _____ Date: __/__/__

Witness Signature: _____ Date: __/__/__

MRN: _____