Community Health Services of Union County, Inc.
CHSUC

1338-C East Sunset Drive – Monroe, NC 28112
(T) 704-296-0909 ● (F) (704) 296-0946 ● info@chsuc.org ● www.CHSUC.org

_______________________________________ ___________________________

Applicant Name (Please print) (Today's Date)

Qualifications:
- **NO insurance** of any kind
- **NO primary care physician**
- **18+ Years of Age**
- **Resident of Union or Anson Counties in NC and Chesterfield or Lancaster Counties in SC**

Please be sure to include the following information with your application. Bring original of each document. Failure to bring documentation will delay the application process and treatment.

☐	Copy of Social Security card (if available) for applicant(s).
☐	Copy of picture identification for applicant(s).

Proof of earned household income:

☐	Current Tax return
☐	Two recent consecutive pay stubs for applicant(s) and other household members, or a letter from employer, on company letterhead, stating rate of pay per hour and number of hours worked *per week* for the past month for applicant(s), if paid in cash.
☐	For Self-Employment income, please list all gross earnings for the last 3 consecutive month(s) and please itemize all work expenses for those same months.

Proof of unearned household income, if applicable:

☐	Food Stamps acceptance letter ___________________
☐	Child Support for ___________________
☐	Social Security Income for ___________________
☐	Unemployment Benefits for ___________________
☐	Workman's Compensation Benefits for ___________________
☐	Housing Assistance Letter(s) of Support
☐	Copy of 2 recent consecutive Checking and Savings Account Statement(s), income from any CD's, Investments, IRA's, 401K, etc.
☐	Current Medicaid denial letter – Are you applying or plan to apply for disability? Yes ☐ No ☐

After you have completed your paperwork, you will call the clinic to schedule an appointment to be screened for eligibility. Your application will then be reviewed and after it is determined that you qualify, you will be contacted to schedule an appointment with our healthcare provider.

We suggest a $20.00 donation for each visit (Cash only, please). We will not deny services to patients due to financial difficulties.

NOTE:
- **We DO NOT complete disability paperwork.**
- **Maternity patients are referred to Health Dept.**
- **We DO NOT prescribe narcotics of any kind nor keep any narcotics in the office.**

PATIENT INSTRUCTIONS AND REQUIREMENTS FOR COMMUNITY HEALTH SERVICES CLINIC

1. Patient cannot have health insurance, Medicaid, Medicare, VA Health Benefits, or Disability Health Benefits.
2. You must fill in all sections of the application packet and return the **completed** forms with **PROOF OF INCOME**. Your income must not exceed an amount pre-determined by this clinic.
3. You must present a picture ID and, if available, a Social Security card.
4. We reserve the right to determine who will be eligible to become a patient. We also reserve the right to discharge patients who do not honor their appointments and/or comply with clinic policies. **Common reasons for patient dismissal:**

   Initial each

   a. ______Failure to show up for scheduled appointments.

      We require that patients call 24 hours prior to their appointment to cancel or re-schedule.

   b. ______ **Drug seeking** (narcotics, pain medicines, etc…).

   c. ______The provider deems the **patient's needs would be better served elsewhere**.

   d. ______ **Patient is not compliant with provider and/or educator's recommendations.**

This clinic is a non-profit institution. The healthcare providers are volunteers. Community Health Services relies on donations from citizens of the community, local organizations and grants in order to serve our patients. We are not affiliated with any hospital or government agency. Our services are limited to basic health care.

Community Health Services will do whatever we can to help; BUT, potential patients are not guaranteed nor entitled to specific services.

By signing this document, you acknowledge that you understand the contents of this document and agree to comply with the clinic's policies. You also ack-nowledge that all the information you supply is true. Your information is kept confidential and will not be shared without your permission.

Applicant's signature____ Date _______________

Patient/Authorized representative*

I understand Community Health Services clinic operates on a limited availability basis. It is not possible for volunteer physicians or staff to be available 24 hours a day, seven days a week. Should I have an emergency after office hours, I will dial 911 or go to the nearest emergency room. If I need non-emergency care when the clinic is closed, I will seek alternative health care options such as a local urgent care center.

Applicant's signature ____Date _______________

Patient/Authorized Representative*

*If Authorized Representative, please indicate relationship to patient:

_____ Spouse _____ Other (Please specify): ____

Policy: Admissions Eligibility

By CHSUC's Mission Statements, it is clear that the purpose of this clinic is to serve the needs of those individuals who, by virtue of their financial status, are unable to provide for primary health care for themselves and/or their families. The Clinic's service area is limited to those individuals living in Union or Anson Counties in NC and Chesterfield or Lancaster Counties in SC.

Eligibility Standards

The CHSUC Eligibility Review Committee is comprised of volunteers, the Executive Director, and Medical Director. **A yearly review will be performed to determine continued eligibility**. The clinic will not serve those who have private or governmental insurance coverage nor those with annual incomes exceeding financial guidelines, set by the clinic. CHSUC reserves the right to refuse services to any potential patient who requires a level of care that exceeds the capability of the Clinic. During eligibility screenings an assessment will be made to determine if the individual qualifies for care. Upon determination, the individual will be so advised. If not eligible, the reason for denial will be documented on their application and their application will be filed for one year. The potential patient can re-apply every six months.

Procedure

When a patient arrives at the Clinic, they will be met by a staff member who will welcome them and have them sign in. If the patient has been seen at the Clinic in the *past,* the staff will obtain their file and update the registration data.

Physician Assignment Policy

A patient who has called for an appointment is to be scheduled to see a healthcare provider, based on the patient's need and the availability of a healthcare provider. If a patient is returning to the Clinic, they will see the same provider, when possible, based on availability.

Non-Discrimination Policy

Community Health Services of Union County shall operate in a manner that does not unlawfully discriminate against people on the basis of race, color, national origin, religion, sex, age, sexual orientation (including gender identity and expression), marital status, disability, veteran status, or any other basis prohibited by federal, state, or local law.

Eligibility criteria for Free Clinic and Education Programs are exclusive to the following:

- Applicants must have no insurance of any kind
- Applicants must be 18-64 years of age
- Applicants must not have gestational diabetes
- Maternity patients are referred to Health Dept.
- Applicants must be residents of Union or Anson Counties in NC and Chesterfield or Lancaster Counties in SC
- Applicants must have no primary care physician

Document remains with applicant

Adopted by the Community Health Services Board of Directors Date: 7-21-2010
Revised 2-19-2019

Community Health Services (CHSUC)

PATIENT'S RIGHTS STATEMENT

CHSUC respects your rights as a patient and recognizes that you are an individual with unique healthcare needs. Because of the importance of respecting each patient's personal dignity, CHSUC provides considerate, respectful care focused upon individual needs.

Current information regarding your diagnosis, treatment, and possible outcomes may be obtained from your physician or nurse.

The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his /her action(s).

Privacy and confidentiality are to be maintained at all times. Information about your condition is to be available only to those who are directly involved in your day-to-day care. If your visit is not the result of a public record accident or injury, you may prohibit information from being released to the public about your condition or your presence here. Any communication or record related to your care is to be treated as confidential, unless the law requires its release as in suspected abuse or public health hazards cases.

You have the right to review the records pertaining to your medical care.

If you have any concerns about your care at CHSUC, the Executive Director is available to assist you. Your care, or that of your family member is not to be negatively affected as a result of making a complaint.

Your personal safety is of the utmost importance to us. CHSUC maintains this through our clinic practices and environmental surroundings.

Whenever possible, decisions should be made at the level closest to the patient, i.e., between the patient and the physician, or between the legal guardian or legal advocate of an incapacitated or otherwise legally incompetent patient and the physician.

The patient may choose to delegate responsibility for treatment decisions. Although the decision for treatment has been delegated, medical treatment should remain consistent with the views of the patient.

Document remains with applicant

All members of the healthcare team should be alert to signs that the patient does not understand clearly what is involved and bring this to the physician's attention. It may be advisable to obtain consultation from other healthcare professionals, translators or significant others sanctioned by the patient.

Information should be shared to allow the patient to participate in decisions about his or her care. The process should include:

- Providing information on the patient's condition.
- Recommending procedure and/or treatment with its significant benefits and risks.
- Significant alternatives for care or treatment (including no specific treatment).
- Likely duration of incapacitation, if any.

- If the patient chooses a course of treatment that is not acceptable to the attending physician or other healthcare professionals, those health care providers may withdraw from the case as long as responsibility for medical care of the patient is transferred to the care of an alternative physician, or an appropriate referral is made.
- If the patient decides to refuse all treatment or chooses a course of treatment not acceptable to the attending physician, thorough documentation of the decision should be placed in the patient's file.
- If the patient decides to refuse all treatment, the patient or surrogate should be informed of the possible medical consequences of his/her action.
- The physician~~s~~ document the patient's choice to refuse treatment in the patient's progress notes. **The patient is to be asked to sign and date the Against Medical Advice Form.**

Document remains with applicant

Adopted by the Community Health Services Board of Directors Date: 7/21/10
Revised 2/19/19

Community Health Services of Union County, Inc.

Free Clinic APPLICATION

(Last Name) (First Name) (MI) (Today's Date)

( ) Female ( ) Male

(Date of Birth) (Age) (Ethnicity) (Gender) (Social Security Number)

(Street Address) (PO Box (mailing only))

(City) (State) (Zip Code)

(Home Phone) (Cell Phone) (Work Phone)

HOUSING:

(Own) (Rent) (Community Shelter) (Staying with Family / Friends) (Homeless) (Other)

Union or Anson Counties in NC and Chesterfield or Lancaster Counties in SC For::

(Years) (Months) **(Number of Family Members in Household)**

MARITAL STATUS:

(Single) (Married) (Divorced) (Widow(er) (Separated)

DO YOU WORK:

(Yes) (No) (If yes, where?) (For how long?) (If no, the last place you worked)

DO YOU CURRENTLY HAVE HEALTH INSURANCE?

(Yes) (No)

HAVE YOU OR ANYONE LISTED IN THIS APPLICATION APPLIED FOR MEDICAID?

(Yes) (No) (If yes, who?)

HAVE YOU OR ANYONE LISTED IN THIS APPLICATION SERVED IN THE U.S. MILITARY?

(Yes) (No) (If yes, when)

HAVE YOU OR ANYONE LISTED IN THIS APPLICATION RETIRED FROM THE U.S. MILITARY?

(Yes) (No) (If yes, when?)

EMERGENCY CONTACT INFORMATION

(Contact Name) (Relationship) (Phone)

(Contact Name) (Relationship) (Phone)

(Contact Name) (Relationship) (Phone)

Signature: ______________________________ ______________

Patient/Authorized Representative (Date)

1338-C East Sunset Drive ● Monroe, NC 28112 ● (T) 704-296-0909 ● (F) 704-296-0946 ● e-mail: info@chsuc.org ● www.CHSUC.org

Monthly Income Review

Applicant Name (Please print) (Date)

(For self-employed applicants, show last 3 months income; all others show 1 month)

Monthly FAMILY INCOME	**Month of**	**Month of**	**Month of**
Gross Income (Self and Family Members)	$	$	$
Child support (receiving)	$	$	$
Alimony (receiving)	$	$	$
Family/Friends support	$	$	$
Unemployment Benefits (Self and Family Members)	$	$	$
Food Stamp, Disability, SSI, Retirement, HUD, Welfare, Etc.	$	$	$
Rental Property Income	$	$	$
Other (please explain)	$	$	$
Total Monthly Gross Income	$	$	$
Total Annual Gross Income	$	$	$
BANK INFORMATION (Monthly)			
Personal Account – Checking & Savings Accounts	$	$	$
Deposits: Checking/Money Market/401K/Other Investments	$	$	$
Deposits: Savings	$	$	$
Business Account:	$	$	$
Deposits: Checking	$	$	$
Total Deposits	$	$	$
Total Annual Gross Income	$	$	$

Please attach a copy of supporting documents above.

Community Health Services of Union County, Inc.

LETTER OF SUPPORT

Date: ______________________

I ____ pay rent and utilities on behalf of, or for
(name of person providing support)

______________________________ . I am not financially responsible for his/her bills,
(person being supported)

nor able to buy his/her medications. I provide room and board in the amount of $_______________
(dollar value of support)

per month.

______________________ ______________________ ______________________
Signature Printed Name Relationship to Patient

____ ______________________
Address Phone Number

***IF MORE THAN ONE PERSON IS SUPPORTING YOU, YOU WILL NEED TO GET A LETTER OF SUPPORT FROM EACH ONE.**

STATEMENT OF NO INCOME: If you have **no** monthly income, please read and sign the following statement:

> **IF YOU HAVE NO INCOME, PLEASE TELL US HOW YOUR HOUSEHOLD BILLS ARE PAID. IF ANOTHER PERSON PAYS THE BILLS, PLEASE PROVIDE A SIGNED LETTER(S) OF SUPPORT.)**
>
> **IT IS VERY IMPORTANT ALL INCOME INFORMATION IS PROVIDED. PROVIDING THIS INFORMATION WILL NOT AUTOMATICALLY DISQUALIFY YOU AS A PATIENT. INCOME GUIDELINES ARE PRE-DETERMINED BY THIS CLINIC.)**

I ____ do not currently have any income,
(patient name)

which includes but is not limited to, wages, unemployment benefits, disability benefits, self-employment income, Social Security or retirement. I understand that it is my responsibility to report to Community Health Services the start of any income within 10 days of its beginnings.

By signing this document I am agreeing that all of the information is accurate to the best of my knowledge.

______________________ ______________________________ __________
Name (print) Signature Date

COMMUNITY HEALTH SERVICES of Union County, Inc.

HEALTH HISTORY

(Last Name) (First Name) (MI) (Today's Date)

( ) Female ( ) Male

(Date of Birth) (Age) (Ethnicity) (Gender) (Social Security Number)

(Street Address) (PO Box (mailing only))

(City) (State) (Zip Code)

(Home Phone) (Cell Phone) (Work Phone)

WHY WOULD YOU LIKE TO MAKE AN APPOINTMENT WITH THE DOCTOR? (WHAT IS THE PROBLEM?)

List current medications (dose & frequency): If there are more, list on a separate attached sheet.	List any medication you are **allergic to** & the reaction you experienced List all other allergies:
List all over-the-counter or herbal medications that you take on a regular basis:	List all previous hospitalizations and surgeries Date

Social History ** please be honest **

1. Do you smoke? __Yes ___No ___Previously?
   If yes, how many packs per day _______ and for how many years?______.
2. Do you drink alcohol? __Yes __No ___Previously?
   If yes, how many drink per day ______ and how many drinks per week? ______.
3. Do you use street drugs? ___Yes ___No ___ Previously?

If yes, what kind? ______________________Have you ever shared needles? __Yes __ No

PATIENT & FAMILY HEALTH HISTORY

Health History: Please write "yes" in the "yes" column if you or a blood relative has ever been treated for the listed condition and then provide the nature of the relationship. (For example: self, mother, father, grandfather, uncle, sister, etc.)

CONDITION	YES	BLOOD RELATIVE/ RELATIONSHIP	CONDITION	YES	BLOOD RELATIVE/ RELATIONSHIP
Anemia			High blood pressure		
Arthritis			Thyroid (hyper or hypo)		
Asthma			Hepatitis		
Bladder Infection			Headaches or Migraines		
Blindness			Heart Attack		
Bronchitis			Heart Failure		
Cataracts			Kidney infections or stones		
Cirrhosis of the liver			Seizures		
Diabetes: Non-insulin			Sexually transmitted diseases		
Diabetes: Insulin			Strokes		
Emphysema			Tuberculosis		
Cancer			Ulcers		
Osteoporosis			High Cholesterol		

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, hereby, authorize the use or disclosure of my identifiable health information, as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider; the released information may no longer be protected by federal privacy regulations.

______________________________ ______________
(Patient Name) (Date of Birth)

____
(Patient's Address)

Information to be released FROM *(to get records from your previous health care provider)*

____
(Facility and/or Dr.'s Name)

____
(Address)

______________________________ ______________
(Phone) (Fax)

Date of services requested: From ____________________ To ____________________

Check information to be released (used or disclosed): ☐Office Notes ☐Radiology Reports/Imaging/X-rays ☐Laboratory/Pathology Reports ☐EKG/Monitors ☐Other (specify) ______________________________

Check purpose of disclosure: ☐Medical Review ☐Legal Review ☐Personal Use ☐Other (specify) ______________________________

Information to be released TO:

Community Health Services of Union County, Inc.
1338-C East Sunset Drive, Monroe, NC 28112
Phone: 704-296-0909 Fax: 704-296-0946

Will the health care provider requesting the authorization receive any financial or in-kind compensation in exchange for using or disclosing the health information described above? ☐Yes ☒ No (office use only)

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/*or* human immunodeficiency virus (HIV). I understand that I have a right to revoke this authorization at any time by notifying the providing organization **in writing**. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Patient/Authorized Representative:

______________ ______________ ______________
Name (print) Signature Date

Community Health Services of Union County, Inc.

Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for Community Health Services of Union County, Inc. detailing how my information may be used and disclosed as permitted under federal and state law.

Signed: ____ **Date:** _______________

If not signed by patient, please print patient's name and indicate your relationship to patient (such as mother, spouse, significant other, etc.).

Patient:____

Relationship: _____________________________________

Authorization to Disclose Personal Health Information

I authorize release of Personal Health Information to the following individuals:

Name: _______________________________________Relationship: ____________________________

Name: _______________________________________Relationship: ____________________________

Name: _______________________________________Relationship: ____________________________

Signed: ____ **Date:** _______________

If not signed by patient, please print patient's name and indicate your relationship to patient (such as mother, spouse, significant other, etc.).

Patient:____

Relationship:_____________________________________

Community Health Services of Union County, Inc.

Prescription Service Limitations

I understand, through CHSUC, I may receive (if funds are available):

- Medical care, as deemed necessary by healthcare providers.
- A one-time, 30-day supply of my prescription medications, when funds are available.

I understand that if I cannot qualify for a Prescription Assistance Program (PAP), such as HealthQuest, MedAssist, etc., which could provide additional prescription refills, I am responsible for the cost of refills and any new prescriptions necessary to effectively treat and control my illness.

Signature: ____Date______________

Staff witness:____

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy permission to disclose information about your prescriptions that have been filled at any pharmacy. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

The medication history is a useful guide, but it may not be completely accurate. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for you to obtain my medication history from my pharmacy.

____
Name (Please print)

____ ____________________________
Signature Date

____
CHSUC Staff Witness

Community Health Services (CHSUC)

No Show Policy

Community Health Services of Union County is an organization operated by staff and community volunteers, who are committed to providing healthcare to uninsured adult residents of Union or Anson Counties in NC and Chesterfield or Lancaster Counties in SC. As a private organization, we have created guidelines you need to understand and **agree upon** to ensure a mutually respectful relationship.

(Please "initial" after each point you read and agree to):

1) I will call to notify CHSUC, 24 hours before my appointment time, if I am unable to attend my scheduled appointment so that this time allotted to me may be used to see someone else in need.____________

2) I will keep (and be on time) for all my scheduled appointments with my medical provider and other members of my treatment team. I understand that I will be dismissed as a patient if I have three (3) "Unexcused No Shows" within a year. _________

3) I understand that CHSUC will discharge me as a patient if I miss or "Do Not Show" for three (3) scheduled appointments within a year. __________

4) I understand that appointment scheduling is based on availability of providers, and there may be delays and occasional need for re-scheduling as well as changes in who I see.__________

5) I agree to update CHSUC immediately if there are any changes in: phone number(s), address, employment information, income changes **or if I obtain medical insurance**.________

6) I understand I will be "immediately" discharged from CHSUC if I am unable to follow these guidelines or I am rude in any way to the staff, healthcare providers or volunteers.________

Patient's signature ______________________________________ Date _________________

On behalf of all our volunteers and staff, we are truly glad to assist you with your healthcare needs. We hope you find us all to be caring professionals. Please inform anyone without health insurance of our availability and desire to serve uninsured, adult residents in Union or Anson Counties in NC and Chesterfield or Lancaster Counties in SC.

The CHSUC Staff

Witness/Reviewed : __________________________________ Date_____________________

Adopted by the Community Health Services Board of Directors Date: 7-21-2010
(Revised 8/30/2017, 2/19/2019)