Community Health Services of Union County, Inc. (CHSUC)

1338-C East Windsor Street – Monroe, NC 28112
(T) 704-296-0909 ● (F) (704) 296-0946 ● CHSUC@Carolina.RR.Com ● CHSUC.org

Applicant Name (Please print) _____ (Date) _____

- Applicants must have **NO insurance** of any kind
- Applicants must be a **Union County Resident**
- Applicants must be **18 – 64** years of age
- Applicants must have **NO physician**

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) 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, 401K, etc.
- ☐ Medicaid denial letter – Are you applying or plan to apply for disability? Yes ☐ No ☐

After you have completed your paperwork, you may 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 a Doctor appointment.

We request a $10.00 donation for each Doctor visit (Cash only please). If your financial situation is dire, please notify the staff. We will not deny services to patients due to financial difficulties.

NOTE:

- **We DO NOT complete disability paperwork.**
- **We do not see pregnant patients.**
- **We do not prescribe narcotics or keep any medications on premises.**

INSTRUCTIONS AND REQUIREMENTS FOR BECOMING A PATIENT OF COMMUNITY HEALTH SERVICES CLINIC

1. You cannot have health insurance, Medicaid nor Medicare.
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:
   a. Failure to show up for scheduled appointments. We require that patients call 24 hours prior to their appointment to cancel or reschedule.
   b. Seeking drugs
   c. The Doctor deems that the patient's needs would be better served elsewhere.

This clinic is a non-profit institution. The Doctors and Nurses 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 acknowledge 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 the volunteer physicians or staff to be available 24 hours a day, seven days a week. Should I ever need emergency medical care, 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 the 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 hea1th care for themselves and/or their families. The Clinic's service area is limited to those individuals living in Union County.

Eligibility Standards
The CHSUC Eligibility Review Committee is comprised of volunteers, the Executive Director, and Medical Director. A 1-year review will be performed to determine continued eligibility. It is not expected that the Clinic will serve those who have private or governmental insurance coverage or make over 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. Eligibility screenings are held by appointment. During that visit an assessment will be made to determine if the individual qualifies for care. Upon that 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 lay volunteer who will welcome them and have them sign in. If the patient has been seen at the Clinic in the *past,* the volunteer will obtain their file and confirm that the printed registration data is correct. The lay volunteer will advise the Charge Nurse of the patient's arrival.

Physician Assignment Policy
A patient who has called for an appointment is to be scheduled to see a doctor based on the patient's need. If a patient is returning to the Clinic, they will see the same doctor, 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 Diabetes Clinic and Diabetes 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
- Applicants must be a Union County, NC Resident
- Applicants must have no physician

Document remains with applicant

Adopted by the Community Health Services Board of Directors Date: 7-21-2010

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.

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.

The presumption will be in favor of the patient's ability to understand the nature and effects of treatment options and to appreciate the impact of a choice. Decision-making capability is not synonymous with the legal term competency.

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.

The following procedure should be followed:

- 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 physicians document the patient's choice to refuse treatment in the patient's progress notes. The patient is to be asked to sign the notes or write his/her own explanation on them.

Document remains with applicant

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

Community Health Services of Union County, Inc.

Diabetes Free Clinic
APPLICATION

(Last Name) _____ (First Name) _____ (MI) _____ (Date) _____

(Date of Birth) _____ (Age) _____ (Ethnicity) _____ ( ) Female ( ) Male (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 COUNTY RESIDENT FOR :

_____ (Years) _____ (Months) _____ (Size of Family)

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) _____

I certify that the above information is correct and grant the staff at Community Health Services of Union County, Inc., permission to release pertinent financial records.

Signature: _____ _____

Patient/Authorized Representation (Date)

Income & Expense Monthly Review

Applicant Name (Please print) (Date)

(For self-employed application 3 months, otherwise 1 month)

INCOME (Monthly)	**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	$	$	$
Other (please explain)	$	$	$
Total Monthly Gross Income	$	$	$
Total Annual Gross Income	$	$	$
BANK INFORMATION (Monthly)			
Personal Account	$	$	$
Deposits: Checking/Money Market	$	$	$
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 and 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) (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):	List any medication you are **allergic to** & the reaction you experienced
If there are more, list on a separate attached sheet.	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? _____ and have you ever shared needles? __Yes __ No

PATIENT & FAMILY'S 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, 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 Windsor Street – 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 **X**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/Authorization Representative:

Name (print) Signature Date

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 (e.g., mother).

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 (e.g., mother).

Patient: _____

Relationship: _____

Community Health Services (CHSUC)

No Show Policy (Revised 1/29/2015)

Community Health Services of Union County is an organization staffed predominantly by volunteers committed to providing healthcare to uninsured people with diabetes in Union County. As a private organization, we have created guidelines you need to understand and agree upon to ensure a mutually respectful relationship between us:

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

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

2) I understand that CHSUC may request a fee if I fail to show for an appointment. The fee will be $10 for the first missed appointment and CHSUC will discharge me as a patient if I miss or "No Show" for 2 scheduled appointments in a calendar year. _____

3) I must have a pre-scheduled appointment to be seen and cannot walk in and demand service. Walk-in appointments are not acceptable. _____

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

5) I agree to update CHSUC immediately if my: phone number(s), address, employment information, or income changes. _____

6) I agree to speak to whoever answers the phone when I call because CHSUC depends on volunteers to share the work. _____

7) I understand I will be discharged from CHSUC if I am unable to follow these guidelines or am discourteous to the staff or volunteers. _____

8) A 1-year review will be performed to determine continued eligibility._____.

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 people with diabetes in Union County.

The CHSUC Staff

Adopted by the Community Health Services Board of Directors Date: 7-21-2010 (Revised 1/29/2015)

Community Health Services of Union County, Inc.

Prescription Service Limitations

I understand through CHSUC I am entitled to:

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

I understand that if I cannot qualify for the HealthQuest Prescription Program, which could provide additional prescription refills, I am responsible for the cost of further refills of any and all prescriptions in order to effectively control my illness.

Name: _____

Date: _____

Staff witness: _____