***DIRECTIONS FOR APPLICATION***

If you are currently on Medicaid, you are

NOT eligible for our services.

*All patients applying for the clinic services must have a diagnosis of at least one of the following five diseases:* **Diabetes, Hypertension, Chronic Lung, Heart, or Thyroid Disease.**

If employed, bring the following financial information:

* + Pay stubs for the last three months *for* ***all*** *household incomes.*
	+ Latest Federal Income Tax paperwork with the W-2 forms.

***Please bring in a copy of all pages to leave here.***

* A copy of the current checking and/or savings account’s original statement. Online print outs are acceptable.
* Any award letters for any pensions or annuities of **anyone** in the household.
* Your Social Security Card.
* Your photo I.D.
* Insurance card (if you have health insurance or medication insurance)
* Any AFDC checks you receive, including award letter for food stamps.
* Medicaid Inquiry Denial or Medicaid Denial letter

Thank you for your cooperation and we look forward to helping you with your medical needs.

|  |  |  |
| --- | --- | --- |
| **Office Hours** | **Doctor Days** | **Pharmacy Days** |
| Monday - Thursday8:30 AM - 5:00 PM | Monday mornings:Sign in by 8:30 AMTuesday afternoons:Sign in by 5:00PM.Doctors start arriving at 1:00 PM. | Thursdays10:30 AM - 12:30 PM1:30 PM - 4:00 PM |

**The Broad Street Clinic Application** Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **NAME:**  |  |
| **BIRTHDAY:**  | **SOCIAL SECURITY #:** |
| **MAILING ADDRESS:** |  |
| **COUNTY:** | **HOME TELEPHONE:** |

**GENDER:** Male Female **RACE:** White Black Hispanic Other

**MARITAL STATUS**: Single Separated Married Divorced Widowed

**EMPLOYED: Yes No YEARS EMPLOYED:\_\_\_\_\_\_ EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARE YOU A VETERAN?** Yes No **DO YOU HAVE V.A. BENEFITS?** Yes No

**EMERGENCY CONTACT INFO:**

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_\_TELEPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*MEDICAL INSURANCE INFORMATION:*

**DO YOU HAVE MEDICAID?** YES NO

**DO YOU HAVE MEDICARE?** YES NO **MEDICARE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OTHER MEDICAL INSURANCE?** YES NO

**INSURANCE CO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURANCE#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL DOCTOR OUTSIDE OF THIS CLINIC:** YES NO

NAME OF DOCTOR**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***HOUSEHOLD INFORMATION:* (List all the people that live in your household)**

**SPOUSE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **NAME** | **AGE** | **RELATIONSHIP:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

***HOUSEHOLD ASSETS:* MUST BRING IN CURRENT BANK STATEMENT!**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Checking Account? | Yes | No | Where: | Balance: |
| Savings Account? | Yes | No | Where: | Balance: |
| Retirement Account? | Yes | No | Where: | Balance: |

|  |  |  |  |
| --- | --- | --- | --- |
| Do you own your own home? | Yes | No | Tax Value: |
| Do you own land? | Yes | No | Tax Value: |
| Do you own other property? | Yes | No | Tax Value: |

**What vehicles are in the household? (Year and Model)**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***HOUSEHOLD MONTHLY INCOME:* (GROSS INCOME)**

**DID YOU FILE INCOME TAXES LAST YEAR? Yes No**

***IF YES, MUST BRING IN INCOME TAX RETURN!***

|  |  |  |
| --- | --- | --- |
| **SOURCE** | ***PATIENT*** | ***OTHER HOUSEHOLD MEMBERS*** |
| Salary/Wages Full-time/Part-time | $ | $ |
| Self-employment | $ | $ |
| Odd Jobs | $ | $ |
| Rental Property | $ | $ |
| Unemployment Insurance | $ | $ |
| Social Security/Disability | $ | $ |
| Supplemental Security Income | $ | $ |
| Retirement/Pension/Annuity | $ | $ |
| Food Stamps | $ | $ |
| TANF (welfare) | $ | $ |
| Child Support | $ | $ |
| Other Sources | $ | $ |
| ***TOTAL INCOME*** | $ | $ |

If Zero income- must complete Zero Income Form. (We have forms.)

|  |  |
| --- | --- |
| **EXPENSE** | **AMOUNT** |
| Mortgage | $ |
| Rent | $ |
| Lot Rent | $ |
| Home Equity Loan | $ |
| Homeowner’s/Renter’s Insurance | $ |
| Utilities | $ |
| Telephone | $ |
| Food | $ |
| Life Insurance | $ |
| Medicare/Supplemental Insurance | $ |
| Car Payment | $ |
| Car Insurance | $ |
| Tithes/Charitable Giving | $ |
| ***Total Expense:*** | $ |

***MONTHLY MEDICAL EXPENSES:***

|  |  |
| --- | --- |
| Doctor Bills paid monthly | $ |
| Hospital Bill paid monthly | $ |
| ***Subtotal*** | **$** |

**OUTSIDE MEDICATIONS PURCHASED BY PATIENT:**

|  |  |
| --- | --- |
| **NAME OF MEDICATION** | **AMOUNT PAID** |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |
|  | $ |

I have completed this form and state that all the above information is true and accurate to the best of my knowledge and ability. I authorize Broad Street Clinic Foundation, Inc. to make all necessary inquires to verify the information in this statement, including a credit report utilizing a credit reporting agency of your choice. I understand that if it is discovered that I have not been truthful that I will lose the privilege of services at Broad Street Clinic Foundation, Inc.

Signature: Patient Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Spouse Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I also understand that if I do not bring in all of my financial documents within two weeks of turning in this application, I may be denied any and all services provided through the Broad Street Clinic Foundation.**

 Signature: Patient Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Spouse Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***CLIENT INFORMED CONSENT AND WAIVERS***

As a client of **Broad Street Clinic Foundation, Inc. (BSCF**) you acknowledge and accept responsibility for the following information and guidelines:

\_\_\_\_**BSCF** is a private not for profit organization that does not receive county, state or federal tax dollars for support.

\_\_\_\_Under North Carolina law, a volunteer medical or health care provider shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or omission in the medical or health care provider’s voluntary provision of health care services unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the volunteer medical or health care provider.

\_\_\_\_You are granting **BSCF** permission to 1) complete **MEDICATION ASSISTANCE PROGRAM APPLICATIONS**, 2) release financial and medical information necessary to complete those applications, and 3) **sign those applications** on your behalf.

\_\_\_\_**BSCF** will do **whatever we can, whenever we can** but you are not guaranteed or promised that the services you need will be provided.

\_\_\_\_If referral services are provided outside of our facility with a charge, the charge belongs to you, the client, **not BSCF**. **BSCF** is not responsible for any charge that occurs outside our facility.

\_\_\_\_Medications that you receive from **BSCF MAY NOT** be in a child safety proof container and must always be **kept out of reach of children.**

\_\_\_\_You are responsible for reading and/or having someone read to you any client information handouts. You are responsible for knowing and following the information and guidelines set forth by **BSCF**.

\_\_\_\_Understand that rudeness or any other unacceptable behavior to staff or fellow patients will not be tolerated. The **BSCF** has the right to refuse service to you at any time.

\_\_\_\_**BSCF** asks for a $5.00 processing fee for each doctor or pharmacy visit. This is not a charge for these services but a fee for processing your visit.

*Interviewers: please review each of these statements with your client before asking them to sign.*

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interviewer’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE BROAD STREET CLINIC NEW PATIENT SURVEY**

**Dear BSC Patient:**

Please take a few minutes to complete this survey. Your information will be used to help us evaluate our services and determine how best to use our limited resources. When you finish please turn the survey in at the front desk. ***Thank you for helping.***

1. **Do you work for a salary or wages?**

Part time Full time Self Employed Temp Agency

1. **Are you currently?**

Drawing unemployment Applying for disability

Receiving disability/ SSI Not working because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Homemaker Care giver for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you :**

18-29 years old 30-39 years old 40-49 years old 50-59 years old 60+ years

1. **How is it best to reach you?**

Home phone Work phone Cell phone Contact person

Letter/mail Email Fax No way to contact

1. **Are you:**

Caucasian African American Latino

Native American Asian Indian Other:\_\_\_\_\_\_\_\_\_

1. **Are you:**

Married Single Separated

Widowed Divorced Living with a significant other

1. **What is your current housing situation?**

Rent Own/buying home Shelter Family

Friend Street Car

1. **Are you:**

Male Female

1. **Do you have a chronic health condition:**

Asthma/Emphysema High Blood Pressure Heart Disease Diabetes

Thyroid High Cholesterol Seizure Disorder Other:\_\_\_\_\_\_\_\_\_\_\_\_

1. **How would you rate your health right now?**

Poor Fair Good Very Good Great

1. **Do you take medications daily?**

YES **If so, how many**?\_\_\_\_\_\_\_\_\_\_\_\_\_ NO **If so, how long have you been without meds**?

1. **Have you been to the emergency room in the last year?** YES NO

If yes, how many times?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you been admitted to the hospital in the last year?** YES NO

If so: when/where/why:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What did you do before coming to this clinic?**

Had insurance Went to private doctor’s office Had Medicaid

Went to ER Didn’t need a doctor