



PRE-SCREENING QUESTIONNAIRE

Part A

You may be eligible for Physicians Reach Out services if you meet all of the following conditions:

1. Resident of Mecklenburg County for at least 6 months
2. Provide proof of Family Income
3. Do you have proof of US Citizenship and or Resident Alien Status? Yes No
4. Have Low Income:

Family of 1 Income Limit: \$21,660	Family of 2 Income Limit: \$29,140
Family of 3 Income Limit: \$36,620	Family of 4 Income Limit: \$44,100

Definition of Family: Mom, Dad, and Children under 18 living with parents

Part B

To help us to determine if you qualify for Physicians Reach Out, please answer the following questions:

1. Are you **Pregnant**? Yes No
2. Are you Eligible for **Veterans' Benefits**? Yes No
3. Are you being treated by a doctor under **Worker's Compensation**? Yes No
4. Have you recently applied for/receiving **Medicaid or Medicare**? Yes No
5. Are you eligible for **Health Insurance** through your or your spouse's job? Yes No

If you answer YES to any of these questions you DO NOT QUALIFY for Physicians Reach Out

6. Do you have more than \$6,000 in a savings and/or checking account? Yes No
7. Have you been to a free or sliding scale clinic within the past two years?

If you feel you meet all the conditions in Part A and you have answered NO to all of the questions in Part B, you may be a candidate for Physicians Reach Out

CUESTIONARIO PRE-CALIFICATORIO

Parte A

Usted puede ser elegible para los servicios de Physicians Reach Out si reúne las siguientes condiciones:

1. Ser residente del Condado de Mecklenburg por al menos 6 meses
2. Presentar prueba de Ingresos Familiar
3. Puede probar que es residente Legal en los Estados Unidos? Si No
4. Tener Bajos Ingresos:

Ingreso Límite para Familia de 1: \$21,660	Ingreso Límite para Familia de 2: \$29,140
Ingreso Limite para Familia de 3: \$36,620	Ingreso Límite para Familia de 4: \$44,100

Definición de Familia: Mamá, Papá, e Hijos menores de 18 que viven con los padres

Parte B

Para ayudarnos a determinar si usted califica para Physicians Reach Out, por favor conteste las siguientes preguntas:

1. ¿Está Embarazada? Sí No
2. ¿Es usted elegible para **Beneficios de Veteranos**? Sí No
3. ¿Ha sido usted tratado por un doctor bajo **Compensación de Trabajo**? Sí No
4. ¿Esta aplicando o recibiendo **Medicaid o Medicare**? Sí No
5. ¿Le han **ofrecido Seguro Médico** a través de su trabajo o de su cónyuge? Sí No

Si usted ha contestado SI a alguna de estas preguntas usted NO CALIFICA para Physicians Reach Out

6. Tiene usted mas de \$6,000 en cuenta de ahorros y/o de cheques? Sí No
7. Ha tenido usted citas medicas en Clínicas gratuitas o de pagos por escala, en los dos ultimos años? Sí No

Si usted considera que reúne todas estas condiciones de la Parte A y ha contestado NO ha todas las preguntas de la Parte B; usted puede ser un candidato para Physicians Reach Out

APPOINTMENT INFORMATION:

Date: _____ Time: _____

**** IF YOU ARE A NON ENGLISH SPEAKING INDIVIDUAL YOU MUST BRING YOUR OWN INTERPRETER******APPLICATION PACKAGE INSTRUCTION**

A non refundable fee of \$20 to cover the administrative costs of processing your application must accompany your application. Payment of the application fee does not guarantee acceptance into the Physicians Reach Out (PRO) program. Even if you are accepted into the PRO program, there is no guarantee that services will be available to you. PRO depends on the voluntary participation of physicians and other health care providers in the community. PRO is partially funded by grants and donations. The PRO program and the services of its volunteers may be terminated at any time in the event volunteers are unavailable or funding is suspended.

In order for you to attend this scheduled appointment you must first obtain a PRO Application Package which contains 6 pages (2 sided each).

The applicant must be present and arrive on time for this interview with completed application and the required supporting documents.

The remaining information on the attached forms must be completed, and you will be interviewed to determine eligibility.

If you aren't sure what a question means or how to answer it, leave it blank and we will talk about it during your interview.

We list most financial documents you will need to provide with your application.

Please look at the list and collect all the documentation you will need.

Please list income and expenses for all adult wage earners living at the address.

If married and applying for individual service, spouses' income and signature must also be included.

The interview process should be about one hour. If you arrive late you may be asked to re-schedule.

If you cannot attend this appointment, please call to cancel within 24 hours prior to your appointment.

Thanks for your interest in Physicians Reach Out!

REQUIRED DOCUMENTATION

The following documents must be attached to all applications **without exception. Originals will not be accepted. Documents will not be returned.**

COPIES MUST BE PROVIDED

- **Photo I.D.** – all applicants 18 and older
- **Social Security Card** for everyone who is in the household
- **Proof of US Citizenship or Resident Alien Status (Passport, Birth Certificate, Vote Registration Card)**
- **Earned income of ALL household members**, even if not applying (18 and over) :
 - Two (2) recent and consecutive pay stubs for EACH wage earner and for EACH job: full, part-time, temporary, seasonal, or free-lance jobs. Must show gross and net income
 - If pay stubs are not available, provide letter of employment specifying gross salary, signed and dated by employer on company letterhead.
 - If doing odd jobs, a written statement from the household members of average earnings per month.
 - Own Business/Self-employee: List detail of Income and Expenses for 3 consecutive months as well as three (3) months of bank statements.
- **Unearned income of ALL household members**, even if not applying (birth and up):
 - ▶ Social Security Benefits Yes No Amount: \$ _____
 - ▶ Unemployment Benefits Yes No Amount: \$ _____
 - ▶ Disability Benefits Yes No Amount: \$ _____
 - ▶ Company Retirement benefits—U.S. or from other country Yes No Amount: \$ _____
 - ▶ Pension Yes No Amount: \$ _____
 - ▶ Welfare Yes No Amount: \$ _____
 - ▶ Child Support Yes No Amount: \$ _____
 - ▶ Housing Assistance (Letter from Housing Authority, HUD, Section 8 or Other Assistance Program) Yes No Amount: \$ _____
 - ▶ TANF (Temporary Assistance to Needy Families) Yes No Amount: \$ _____
 - ▶ Workman’s Compensation Yes No Amount: \$ _____
 - ▶ Food Stamps Yes No Amount: \$ _____
 - ▶ Letter of support from friend/family member which includes the value of support on it (give support form to have completed)
- **Most CURRENT and COMPLETE Bank Statement** for all household members (Money Market, CD, Saving, Checking)
- **Proof of residency in Mecklenburg County for the past 6 months** (lease, utility bill dated back 6 months, etc.)
- **Health Insurance Information Request**
- **Clinic Referral?** Bethesda/C.W. Williams/Charlotte Community Health Clinic/Charlotte Volunteers/Free Clinic of Our Town/Lake Norman Free Clinic/Matthews Volunteers/Others _____

BRING ORIGINALS (WE DO NOT NEED COPIES)

- **Tax Return** (Personal and Business_)
 - Current year Income Tax Return, Form 1040 and 1040EZ, as filed with the Internal Revenue Service (IRS). IRS can be contacted at 1-800-829-1040
- **Copy of all your bills (household expenses):**
 - Lease or Mortgage coupon, Water, Gas/Electricity, Telephone, Cable/Direct TV/Dish, Internet, Vehicle Payment, Vehicle Insurance, Child Support, Alimony.



Approved

Denied

NEW

Expiration Date ____ / ____ / ____

Last Name		First Name		MI	SSN / W-7 / Cares ID			
NBA ID <i>(Please leave in blank)</i>		Birth Date: mm/dd/yyyy		Age	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		Race	
Street Address				P. O. Box <i>(mailing only)</i>				
City		State		Zip Code				
Home Phone		Alternative Phone		Cell Phone		Work Phone		
Email Address:								
Applicant's Primary Care Physician				Applicant's Specialist				
Spouse's Primary Care Physician				Spouse's Specialist				
Children's Primary Care Physician				Children's Specialist				
Emergency Contact Name			Relationship		Phone Number			
Language			Need Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Housing: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Community Shelter <input type="checkbox"/> Staying with Family/Friends <input type="checkbox"/> Homeless				Lived in Mecklenburg for: _____ yrs. _____ months				
Household Name <i>(Please leave in blank)</i>			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Separated <input type="checkbox"/> Civil Union				Family Size	
List Family Members (Only spouse and children)								
Last Name	First Name	Relationship	DOB mm/dd/yy	Sex F/M	Marital Status	Race	SS # or W-7	Applying for this person?
1.			/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
2.			/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
3.			/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
4.			/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
5.			/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
6.			/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
7.			/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
8.			/ /					<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or anyone listed in this application applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Who?</i>								
Have you or anyone listed in this application served the U.S. Military? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Who?</i>								

EXPENSES (Monthly)

*Please attach copy of supporting documents
above*

Rent/Mortgage	\$
Water	\$
Gas/Electricity	\$
Telephone (listed in your name)	\$
Cable/Direct TV/Dish	\$
Internet	\$
Food	\$
Vehicle Payment (monthly)	\$
Vehicle Insurance (monthly)	\$
Gasoline	\$
Medical/Dental Expenses	\$
Tuition/College Loans	\$
Child Support (paying)	\$
Alimony (paying)	\$
Child Care	\$
Entertainment/Vacation	\$
Property Taxes (break it down in 12)	\$
House insurance (break it down in 12)	\$
Total Monthly Expenses	\$

Applicant's Signature

Spouse's Signature

Date: ____/____/____

Patient Acceptance of Program Guidelines

Physicians Reach Out, a Care Ring program, is not an insurance plan. Physicians Reach Out offers free or discounted health services donated by Physicians Reach Out, its physicians, partners and other providers. There is no guarantee that health services will be available to you, or that your health will improve. As long as the Physicians Reach Out program continues, every effort will be made to provide you with the health services requested by your assigned Physicians Reach Out doctor. To continue to receive services, you must maintain your eligibility and follow the program guidelines. Your Physicians Reach Out ID card will be accepted only by the doctor assigned to you by Physicians Reach Out, and then only if you have followed the guidelines below.

You agree to:

1. Keep each doctor's appointment. If you miss 2 or more appointments in 12 months, without letting the **doctor's office** know at least 24 hours before your appointment, you may be dismissed from the program.
2. Present your Physicians Reach Out ID card each time you see a doctor.
3. Call your Physicians Reach Out doctor for all questions about your care. **You must call your Physicians Reach Out doctor before going to the emergency room, unless you have a life-threatening emergency.**
4. Follow your treatment plan. For example, get prescribed medicines and take as directed.
5. **Pay all required fees or make payment arrangements with the provider in advance of treatment.**
6. **Use your assigned doctor and hospital. You cannot change your doctor or hospital without permission from Physicians Reach Out.**
7. Promptly supply any information requested by your doctor or Physicians Reach Out.
8. Report all income and health information accurately and completely.
9. Allow your Physicians Reach Out doctor to share your medical information with Physicians Reach Out, to coordinate your health care. You will be given a separate consent form to sign about your medical information.
10. Allow Physicians Reach Out to share information about your participation in Physicians Reach Out with other individuals, organizations and agencies.
11. Remain aware of the expiration date of your eligibility. Do not seek treatment as a Physicians Reach Out patient after you are no longer eligible for treatment. Apply for renewal, when notified by Physicians Reach Out, before your expiration date.
12. Immediately contact Physicians Reach Out at 704-371-4740 if your income changes or you become covered by Medicare, Medicaid, private insurance, other health insurance or medical benefits.
13. Apply for Medicaid or other assistance if Physicians Reach Out asks you to.
14. Contact Physicians Reach Out at 704-371-4740 immediately with any changes in your address, phone number, or number of family members.
15. Treat all doctors, office staff, and Physicians Reach Out volunteers with respect.
16. Avoid the use of illegal substances and illegal behaviors.

By signing below, you agree to follow these guidelines. If you do not follow the guidelines, you may be dismissed from Physicians Reach Out.

Patient/Guardian Signature

Spouse's Signature

Date ____ / ____ / ____



Notice of Patient Information Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Physicians Reach Out’s Legal Duty

Physicians Reach Out, a Care Ring program, is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Physicians Reach Out uses your personal health information primarily for allowing you access to treatment; obtaining payment for your treatment; conducting internal administrative activities and evaluating the quality of care provided. For example, Physicians Reach Out may use your personal health information to contact you to provide information on program responsibilities, medication limits or other health related benefits that could be of interest to you.

Physicians Reach Out may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies.

We also provide information when required by law.

In any other situation, Physicians Reach Out’s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Physicians Reach Out may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted. You may also request an updated copy of our Notice of Information Practices at any time.

Client’s Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Physicians Reach Out will consider all such requests on a case by case basis, but Physicians Reach Out is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Physicians Reach Out may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Physicians Reach Out’s health information practices or if you have a complaint, please contact the following person:

Dearsley Vernon
601 E. 5th Street, Suite 150
Charlotte, NC 28202
Telephone: 704-371-4740
Fax: 704-943-3747

Date: _____/_____/_____

Patient / Guardian Signature

Acknowledgment

I authorize Physicians Reach Out, a Care Ring program, to contact me, and leave a message if not available, for the purpose of providing information regarding my care by the following methods:

Home Phone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Home Phone Answering Machine	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cell Phone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cell Phone Voicemail	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Work Phone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Work Phone Voicemail	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Persons permitted to receive your information:

1. **Name:** _____ **Relationship** _____ **Phone:** _____
 2. **Name:** _____ **Relationship** _____ **Phone:** _____

Date: _____/_____/_____

Patient / Guardian's Signature

Spouse's Signature

Have you been to any appointments at any of these clinics in Mecklenburg County in the last 24 months? *(Please check all that apply and include reason for visit at each location.)*

Carolinas Medical Center
Biddle Point Sliding Scale Clinic
1801 Rozzelles Ferry Road

Carolinas Medical Center
North Park Sliding Scale Clinic
251 Eastway Drive

Carolinas Medical Center
Eastland Sliding Scale Clinic
5516 Central Avenue

Carolinas Medical Center
Myers Park Sliding Scale Clinic
1350 S. Kings Drive

C. W. Williams (formerly called
Metrolina)
3333 Wilkinson Blvd
1918 Randolph Rd.

Free Clinic of Our Town
(Ada Jenkins)
212 Gamble St.

Charlotte Community Health Clinic
3040 A Eastway Drive

Matthews Heath Clinic
113 Ames St.

Bethesda Health Center
133 Stetson Drive

Lake Norman Free Clinic
121 N Old Statesville Rd.

Charlotte Volunteers in Medicine
1330 Spring St.

**Carolinas Medical Center
Myers Park Sliding Scale Clinic**
1350 S. Kings Drive

**Charlotte Community Health
Clinic**
3040 A Eastway Drive

Lake Norman Free Clinic
121 N Old Statesville Rd.

C. W. Williams(formerly called
Metrolina)

3333 Wilkinson Blvd
1918 Randolph Rd.

Matthews Heath Clinic
113 Ames St.

Free Clinic of Our Town
(Ada Jenkins)
212 Gamble St.

Bethesda Health Center
133 Stetson Drive

12. Have you had health insurance in the past? Yes No

**If you answered yes, please tell us why you do not currently have it:

Tell Us Your Healthcare Story

Care Ring collects personal healthcare stories to help lawmakers, the media and the public understand the importance of everyone having access to affordable, quality healthcare. Everyone has a valuable story to tell! Sharing your story shows the real life experiences and struggles people in our community face accessing healthcare.

We will never use your story without your consent and without contacting you first. Your identity and personal information will remain confidential.

Name: _____

Address: _____

Phone Number: _____ (home) _____ (cell)

Email Address: _____

Would you also be interested in learning more about healthcare reform and/or making a phone call to voice your healthcare needs to your members of Congress?

Please tell us your story in the space below. It may help to start with:

Not having health insurance has meant that...

I delayed going to the doctor because...

I am worried about not having health insurance because...

I am worried about health care costs because...

Please use the back of this sheet if you need more space. Thank you for sharing your story!

For more information or to send us your story, contact us by:

Phone: (704) 248-3724 Fax: (704) 943-3748 Email: kbenston@careringnc.org

LETTER OF SUPPORT

Date: _____

I, _____ (name of person providing support),
pay rent and utilities on behalf of *or* for _____ (person
being supported). I am not financially responsible for his /her bills or able to buy his /her
medications. I provide room and board in the amount of \$ _____ per month (dollar value
of support).

Signature

Printed Name

Address

Phone Number

CARTA DE SOPORTE

Fecha: _____

Yo, _____ (nombre de la persona que le brinda el apoyo) certifico que pago la renta y servicios (electricidad, teléfono, agua) a favor de _____ (nombre de la persona beneficiada). A la vez aclaro que no soy responsable financieramente del pago de sus deudas ni estoy en condiciones de suministrarle sus medicinas. Yo le proveo vivienda y/o comida por el valor de \$ _____ al mes (valor del apoyo).

Firma

Nombre y Apellido

Dirección

Teléfono

HEALTH INSURANCE INFORMATION REQUEST

To be completed by Employer Only

Please answer the following questions regarding the employee:

1. Is **HEALTH INSURANCE** currently available for his/her purchase through the company?
 Yes **No**

If the answer is NO, will he/she be eligible on a future date? **Yes** **No**
On What Date? ____/____/____

2. If the health insurance is available currently *or* in the future, is it also available for purchase for his/her family members? **Yes** **No**

3. When is Open Enrollment Season for health insurance through the company? ____
/ ____ / ____

4. If employee chooses to enroll in the insurance plan through the company, what date will the insurance take effect? ? ____/____/____

5. How much would the Monthly Premium be?

Individual \$ _____ **Family** \$ _____

6. How much would the Deductible be?

Individual \$ _____ **Family** \$ _____

PLEASE ATTACH THE SUMMARY OF BENEFITS FOR EACH PLAN

Date: ____/____/____

Manager's Name _____

Manager's Signature: _____

Please Remember to Attach Your Business Card or Business Stamp!!

INFORMACIÓN DE SEGURO DE SALUD

Para completar únicamente por Empleador

Por favor responder las siguientes preguntas en referencia a su empleado

1. ¿Es actualmente ofrecido **SEGURO DE SALUD** para su empleado(a) a través de su compañía? **Sí** **No**

Si la pregunta es NO, será elegible en una fecha futura? **Sí** **No**
En qué día? ____/____/____

2. Si el Seguro de Salud es disponible actualmente o en un futuro, es disponible para el resto de los miembros de la familia? **Sí** **No**

3. ¿Cuándo es la fecha de Apertura para la Inscripción? ____/____/____

4. Si el empleado decide inscribirse en el Plan de Salud, ¿Cuándo sería efectivo el mismo? ____/____/____

5. ¿Cuánto sería el valor Mensual del Premium?

Individual \$ _____ **Familiar** \$ _____

6. ¿Cuánto sería el valor del Deducible?

Individual \$ _____ **Familiar** \$ _____

POR FAVOR ADJUNTE EL SUMARIO DE BENEFICIOS POR CADA PLAN

Día: ____/____/____

Nombre del Manager _____

Firma del Manager: _____

Por favor Recuerde Adjuntar su Tarjeta de Presentación o Estampilla del Negocio