



## HealthNet Cabarrus and MedAssist Application Checklist

For Adults, living in Cabarrus County who have a diagnosed chronic medical illness & are not eligible for healthcare insurance, Medicaid or Medicare

<b>Complete these documents</b>
Complete and sign the 2 page application—provided at Community Free Clinic or <a href="http://communityfreeclinic.org">communityfreeclinic.org</a>
<b>Gather these documents</b>
<b>Proof of where you live in Cabarrus County</b> - one of these examples <ul style="list-style-type: none"><li>• NC Driver license or NC Photo Identification card with your current address <b>OR</b></li><li>• Lease agreement if you rent; Property/real-estate tax if you own your home <b>OR</b></li><li>• Bill mailed to your current address - Water, Electric, Gas, Phone, Cable or Medical bill</li></ul>
<b>Proof of all income that you <i>or your spouse</i> earn -</b> <ul style="list-style-type: none"><li>• Pay stubs/Self-employment records/employer letter (for the last 30 days)</li><li>• Disability Income -Current year benefit letter</li><li>• Alimony/Child Support -Letter of Agreement, On-line record of amount, or Court Orders</li><li>• Social Security Income* -Current year benefit letter for any household members</li></ul> <p>* if 65 years old and not eligible for Medicare – a Medicare denial letter is required</p> <ul style="list-style-type: none"><li>• Pension/Retirement -Current Benefit Letter</li><li>• Unemployment/Workers Comp -Benefit letter showing monthly amount</li></ul>
If you do not have income, a <b>Zero Income Form</b> must be filled out and signed. If someone is helping support you, the section ' <b>Letter of support</b> ' should also be completed and signed by any person providing you support. (extras available)
<b>Proof of Taxes paid</b> <ul style="list-style-type: none"><li>• Most recent tax return (1040).</li><li>• Form 4506T -<u>if you (and your spouse) did not file taxes, complete and sign</u></li></ul>
<b>Signed application and all needed documents should be delivered to the Community Free Clinic. Everything may be mailed, left in drop box or brought to Community Free Clinic at 528 A Lake Concord Road, Concord NC -- NOTHING can be approved until ALL needed items are received</b>
Once approved for Cabarrus HealthNet, you will receive your personal Cabarrus Pink Card.
<b>Community Free Clinic, 528-A Lake Concord Road, NE Concord, NC 28025</b> <b>Phone: 980-498-3069</b> <b>Enrollment Hours: Tuesdays and Thursdays 9-11 AM; Wednesdays 1-3 PM</b>



4428 Taggart Creek Road, Suite 101  
 Charlotte, NC 28208  
 Toll Free: (866) 331-1348  
 Local: (704) 536-1790  
 Fax: (704) 536-9865

### ENROLLMENT APPLICATION

For office Use Only			
Date Entered	Temp Date	Recert Date	POE

First Name:	MI:	Last Name:	Social Security Number:	Birth Date:
Mailing address:		City:	State:	Zip:
Email Address:			Primary Phone #:	Secondary Phone #:
Emergency Contact (name other than applicant):			Emergency Contact Phone #:	
North Carolina County of Residency:			Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
Name of Healthcare Provider or Doctor:			Doctor's Phone #:	

Do you smoke?    Yes    No   If yes, are you interested in quitting?    Yes    No

Are you allergic to any medications?    Yes    No   If yes, list: \_\_\_\_\_

How did you hear about the NC MedAssist program? \_\_\_\_\_

<b>Ethnicity:</b> <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Indian <input type="checkbox"/> Other	<b>Primary Language Spoken:</b> <i>(other than English)</i> _____	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Number of People in Household:</b> <i>(including self)</i> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6   Other _____
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<b>List and Attach all Household Income:</b>  Salary/Wages                    \$ _____ Disability                         \$ _____ Alimony/ Child Support        \$ _____ Social Security                    \$ _____ Pension/Retirement            \$ _____ Unemployment/Work Comp      \$ _____ Gross Monthly Income            \$ _____  <b>Total Gross Annual Income        \$ _____</b>	<b>Do you have any of the following forms of Insurance?</b>  Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part D <input type="checkbox"/> Yes <input type="checkbox"/> No Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No Family Planning <input type="checkbox"/> Yes <input type="checkbox"/> No VA Health <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Applicant's Agreement/Disclosure/Release**

I attest that the information I have given in this enrollment application is accurate and true. I also understand that even if my application is approved, services are not guaranteed. By signing this application I release NC MedAssist, its affiliated drug companies and any public or private agencies or financial supporters and their agents from any and all claims of liability in contract or tort arising out of the actions of NC MedAssist, its agents, employees, or P.O.E in performing services or related to services I receive from NC MedAssist. I give my consent to DSS and DHHS to advise NC MedAssist of the status of a pending Medicaid application. I will promptly notify NC MedAssist if I become eligible for Medicare, Medicaid, private insurance or VA benefits, or if my income changes. I also give consent to NC MedAssist to disseminate my health information to its affiliates (i.e. audits by pharmaceutical companies) as it pertains to all federal, state and local laws and regulations and purposes directly related to the administration of NC MedAssist programs and grants. I have received NC MedAssist's Notice of Privacy Practices Statement. I give my permission to NC MedAssist to sign my name on Patient Assistance Program documents when necessary.

I authorize NC MedAssist to ship my medications to the Sponsoring Point of Entry Community Free Clinic  
Enter name of Sponsoring Point of Entry

Name of Enrollment Site (if applicable) \_\_\_\_\_  
This line is intended for the enrollment site only

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

NC MedAssist Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Name/Nombre: \_\_\_\_\_

Date of Birth/Fecha de Nacimiento \_\_\_\_\_

How many people live in your household? ¿Cuántas personas viven en su casa? \_\_\_\_\_

Please list the following for all living in the household: Por favor, liste todos los que viven en el hogar:

Name/Nombre	Date of Birth/Fecha de Nacimiento	Relationship to you/Relación Contigo
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Check any medical condition you have: Por favor, marque sus condiciones médicas crónicas:

<input type="checkbox"/> Hypertension (high blood pressure)/Presión Alta	<input type="checkbox"/> Diabetes
<input type="checkbox"/> GERD/Reflujo	<input type="checkbox"/> COPD or Asthma/Enfermedad pulmonar obstructiva crónica
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer
<input type="checkbox"/> Seizures/Ataques	<input type="checkbox"/> Hepatitis C (hep C)
<input type="checkbox"/> Coronary Artery Disease (CAD)/Enfermedad de las arterias coronarias	<input type="checkbox"/> High Cholesterol/Colesterol Alto

List any additional conditions not checked above      Lista condiciones adicionales marcadas

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My normal mode of transportation is:

- Car
- Bus
- Walk
- Ride with other
- Other (please list below):

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Mi método normal de transportación es:

- Carro
- Autobús
- Camina
- Con otra persona
- Otro método (explique por favor):

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HealthNet  Cabarrus  
HealthNet Cabarrus and MedAssist Application

Zero Income Form

I, \_\_\_\_\_ confirm I am not working and do not have income for support. I am able to receive mail at the following address (which is listed on my application): \_\_\_\_\_

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

Letter of Support

I am providing support for \_\_\_\_\_ in the following fashion:  
(Print Patient's Name)

Check only one of the three boxes below:

- Lives with me at the address below and receives free room and board
- Lives with me and shares expenses. My contribution to expenses is indicated below
- Does not live with me but I provide support as indicated below

I provide cash and other funding in the approximate amounts indicated below. Enter an approximate dollar amounts for each item and check whether this amount is provided weekly or monthly. If you do not provide cash or other funding for a particular item, enter "\$0".

Food: \$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Housing \$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Utilities \$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Cash \$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Other: (explain below) \$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

\_\_\_\_\_  
Sign your name

\_\_\_\_\_  
Print your name

\_\_\_\_\_  
Print your Street Address

\_\_\_\_\_  
Print your City, State and Zip Code

\_\_\_\_\_  
Date

**Request for Transcript of Tax Return**

OMB No. 1545-1872

- ▶ Do not sign this form unless all applicable lines have been completed.
- ▶ Request may be rejected if the form is incomplete or illegible.
- ▶ For more information about Form 4506-T, visit [www.irs.gov/form4506t](http://www.irs.gov/form4506t).

**Tip.** Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at [IRS.gov](http://IRS.gov) and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return**. There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return
3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)	
4 Previous address shown on the last return filed if different from line 3 (see instructions)	
5a If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.  NC MedAssist, 4428 Taggart Creek Rd, Suite 101, Charlotte, NC, 28208, 704-536-1790	
5b Customer file number (if applicable) (see instructions)	

**Caution:** If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶

a **Return Transcript**, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . .

b **Account Transcript**, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . . . . .

c **Record of Account**, which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . .

7 **Verification of Nonfiling**, which is proof from the IRS that you did not file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . . . .

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . . . . .

**Caution:** If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12	/	31	/	2018	/	/	/	/	/
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**Caution:** Do not sign this form unless all applicable lines have been completed.

**Signature of taxpayer(s).** I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

**Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.**

Signature (see instructions)	Date		Phone number of taxpayer on line 1a or 2a
Title (if line 1a above is a corporation, partnership, estate, or trust)			
Spouse's signature	Date		

# HealthNet Cabarrus

The Patient Agreement signature page is to be signed by HealthNet Cabarrus Pink Card Program enrollee and a Community Free Clinic representative. This signature page will remain in the enrollee's chart (with the enrollee's application) and serves to verify the information contained in the application is correct & accurate. HealthNet Cabarrus Pink Card Program enrollee receives the Patient Agreement pages for future reference & for their records.

I authorize the release of any information necessary to establish mine or my family's eligibility. I authorize the Community Free Clinic to verify with state or federal agencies, and other related agencies the information contained in my application and/or shared verbally to complete my enrollment in the HealthNet Cabarrus Pink Card Program and MedAssist. I understand this information may include medical or non-medical information and may be gained from relevant sources such as medical practices, banks, employers, and insurance companies.

Once enrolled in HealthNet Cabarrus Pink Card Program and MedAssist, I agree to allow Community Free Clinic to receive on my behalf the necessary health records, referrals and prescriptions and to release those health records, referrals and prescriptions to healthcare providers participating in HealthNet Cabarrus Pink Card Program in an effort to provide services on my behalf.

I have either read or had read to me, the HealthNet Cabarrus Pink Card Program Patient Agreement including program enrollment responsibilities, and reasons for termination. I understand my responsibilities as a person applying for HealthNet Cabarrus Pink Card Program and MedAssist program services. I agree to these terms.

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Community Free Clinic Representative

\_\_\_\_\_  
Date

## HEALTHNET CABARRUS PATIENT AGREEMENT

### Welcome to HealthNet and MedAssist Prescription Assistance

Enrollment in HealthNet Cabarrus provides you a Medical Home for your ongoing health needs. The doctor, clinic, laboratory, or specialist that is caring for you is NOT paid to give you care – HealthNet is not an insurance program. But you MUST show your HealthNet (Pink Card) at each visit so they will know you are enrolled in HealthNet. Your care while enrolled in HealthNet is because of a partnership between Atrium-NorthEast, Cabarrus County medical practices, MedAssist, and the Community Free Clinic. Its purpose is to provide a healthcare safety net for the uninsured in our county by providing a medical home, access to medications, needed testing, and specialty care. It is an assistance program, not insurance. Please follow all the guidelines for HealthNet and MedAssist and protect this partnership for your future health needs.

You are enrolled for one year – you must *recertify (or enroll)* each year to continue participation in HealthNet. Remember to look at your card to see your dates of eligibility; the Community Free Clinic will send a reminder when it is time to recertify. If your enrollment expires you will not have clinic or pharmacy services until you are re-enrolled.

### Clinical Care for HealthNet Patients:

- Show your HealthNet (Pink Card) at every doctor or clinic visit.
- When you call for appointments tell them you are in HealthNet (Pink Card).
- There are a very limited number of appointments available each month, so call early and always show up for your appointments.
- Do not make appointments with anyone but your doctor or clinic (as stated on your Pink Card). If you need care by anyone else, the doctor or clinic will need to request this service for you.
- Please remember that the doctors who participate in this program do not get paid. They DONATE all the services they provide you. There may be some services that doctors are not able to provide to you.
- Do not use the emergency room for treatment of non-life threatening conditions.
- If you go to the emergency room without a life threatening emergency you are responsible for the charges.
- Ambulance Services (911) are not included in HealthNet (Pink Card). You will pay for those.

### Pharmacy Services through MedAssist Program

- The prescriptions your doctor orders will be filled & provided by MedAssist. Your medicine(s) will be sent to the Community Free Clinic Pharmacy for you to pick up.
- Your doctor or clinic will need to send your prescriptions to the Community Free Clinic Pharmacy. Your medicines will not be here immediately. Your prescriptions are filled by MedAssist Pharmacy in Charlotte then sent to our Community Free Clinic Pharmacy.
- When you need your medicine refilled, you will call your refills into MedAssist directly. **Their phone number is on your medicine bottles.** Your medicines will not be here immediately. Your prescriptions are filled by MedAssist Pharmacy in Charlotte then sent to our Community Free Clinic Pharmacy.
- Your medicine bottle(s) tells how many refills you have. When you have no more refills, call your doctor or clinic to send a new prescription(s) to the Community Free Clinic Pharmacy.

- If you have an urgent need, you will need to make arrangements with your doctor for no cost or low cost medications at other commercial pharmacies until your medications arrive from the MedAssist Pharmacy.

### Dental Services

- There is a dental service for this program. The only service provided is extractions (teeth pulled) and appointments are scheduled for our Night Clinic on the 2<sup>nd</sup> Tuesday of each month. Call the Community Free Clinic to schedule an appointment (704-782-0650).

### **When enrolled in HealthNet (Pink Card), you understand and agree:**

1. You will present your HealthNet (Pink Card) Patient ID card each time you see a doctor.
2. **You can only use your HealthNet (Pink Card) card at the office(s) that HealthNet has assigned you to.**
3. You will keep each doctor's appointment or call and cancel or reschedule at least 24 hours prior to the appointment.
4. You will follow your doctor's orders and recommendations. For example, you will pick up the medicines prescribed for you and take them as they are prescribed for you.
5. You will take all of your current medications with you to every doctor's appointment.
6. You will treat all staff in all clinics and medical practices with courtesy and respect.
7. You will promptly give us any information that we need from you.
8. You will allow all information concerning your participation in this program to be shared with other individuals, organizations and agencies as needed to obtain and maintain enrollment in medical care and medication assistance.
9. **You will apply for Medicaid or other assistance at our request or another provider.**

### POSSIBLE REASON FOR TERMINATION OR DISQUALIFICATION

1. You are eligible for Medicaid, Medicare, or have access to health insurance.
2. "No Shows" If you miss three (3) appointment at your doctor or clinic. If you miss one (1) appointment with a specialist or laboratory providing you HealthNet (Pink Card) services.
3. If you use the Emergency Department for non-emergency illnesses, you may be dismissed from HealthNet and be responsible for the bill.
4. Being disrespectful or uncooperative with any clinic or medical practice staff may cause your removal from HealthNet (Pink Card) services.

While you are enrolled in HealthNet (Pink Card) you agree to notify the Community Free Clinic in any changes in your residency, phone number, employment and financial resources. These changes must be reported within 10 days of the change. If any of your application information and/or support documents is falsified, you will be terminated immediately. You will be given this document for future reference. If you have questions, please contact Community Free Clinic, Enrollment Services: 980-498-3069.