HealthNet **** Cabarrus

HealthNet Pink card Checklist

For adults between ages 19- and 64-years old living in Cabarrus County or Kannapolis that are not eligible for healthcare insurance, Medicaid, or Medicare

|  |
| --- |
| **Complete these documents** |
| Complete and sign the application – provided at Community Free Clinic or [communityfreeclinic.org](file:///\\server-dc\Public\Enrollment\Application%20HealthNet%20documents\English\communityfreeclinic.org). |
| **Gather these documents** |
| **Proof of where you live in Cabarrus County- one of these examples:**   * NC Driver License or NC Photo Identification card with your current address **Or** * Lease agreement if you rent; property/real-estate tax if you own your home  **Or** * Bill mailed to your current address- Water, Electric, Gas, Phone, Cable, or Medical Bill |
| **Proof of all income that you or your spouse (if married) earn –**   * Pay stubs/Self-employment records/official employer letter (for the last 30 days) * Disability Income – Current year benefit letter * Social Security Income\* - Current year benefit letter for any household members   If 65 years old and not eligible for Medicare – **a Medicare Denial letter is required**   * Pension/Retirement – Current Benefit Letter * Unemployment/Worker’s Comp- Benefit letter showing monthly amount |
| **Signed application and all needed documents should be delivered to the Community Free Clinic. Everything may be mailed or left in the drop box located at the Main Entrance (facing Lake Concord Street).** |
| **PLEASE UNDERSTAND THAT NOTHING CAN BE APPROVED UNTIL ALL ITEMS ARE RECEIVED** |
| **Community Free Clinic, 528-A Lake Concord Road, NE Concord, NC 28025**  **Phone: 980-498-3069**  **Fax: 704-705-2741**  **Enrollment Hours: Monday-Thursday from 8:30am to 4:30pm**  **Online at communityfreeclinic.org** |

HealthNet CFC logo(heart only)Cabarrus

Application for the Pink Card Program

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Maiden Last

Sex: \_\_\_M \_\_\_F Race: \_\_\_\_\_ Age: \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: □ Married □ Single □ Separated □ Divorced □ Widowed □ Living with significant other

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Maiden Last

SSN/ITIN \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Are you a Cabarrus County Resident? □ Yes □ No

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Best Contact Number ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

EmergencyContactName/Phone/Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How did you hear about the clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you employed? □ Yes □ No Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you filing for disability or Medicaid? □ Yes □ No

Are you a veteran? □ Yes □ No

**Your Household Income must be at/or below 200% FPL (Federal Poverty Level)**

# In Household Monthly Income Annual Income (1) $2,217 $25,520

(2) $2,873 $34,480

(3) $3,620 $43,440

(4) $4,367 $52,400

(5) $5,113 $61,300

**HOUSEHOLD GROSS MONTHLY INCOME**

Salary/wages \_\_\_\_\_\_\_\_ Disability \_\_\_\_\_\_\_

Social Security \_\_\_\_\_\_\_\_ Worker’s Comp \_\_\_\_\_\_\_

Unemployment \_\_\_\_\_\_\_\_ Self-employment \_\_\_\_\_\_\_

Pension \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_

# Of adults in Household: \_\_\_\_\_\_\_ # of children in Household \_\_\_\_\_

**I certify that I am not currently working and have no income** \_\_\_\_\_\_\_Initial

NOTE: 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. I will promptly notify Community Free Clinic if I become eligible for Medicare, Medicaid, private insurance, or VA benefits, or if my income changes. I also give consent to Community Free Clinic 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 Community Free Clinic program services, and grants. I have received the HealthNet Cabarrus Pink Card Patient Agreement

Applicant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

***PATIENT HEALTH HISTORY FORM***

HealthNet ****Cabarrus

**Application for HealthNet Cabarrus, Page 2** Solicitud de HealthNet Cabarrus, Página 2

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

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

**Name of Healthcare Provider**/Nombre de su Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please enlist allergies you have /**Enliste allergias que tenga **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all your dependents in the household**/Por favor, liste todos los que dependen de Usted:

**Name**/Nombre **Date of Birth**/Fecha de Nacimiento **Relationship to you**/RelaciónContigo

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| * Hypertension (high blood pressure)/Presión Alta | * Diabetes |
| * GERD/Reflujo | * COPD or Asthma/Enfermedad pulmonar obstructiva crónica |
| * Anemia | * Cancer |
| * Seizures/Ataques | * Hepatitis C (hep C) |
| * Coronary Artery Disease (CAD)/Enfermedad de las arterias coronarias | * High Cholesterol/Colesterol Alto |

**Check any medical condition you have**: Por favor, marque sus condiciones cronicas

**List any additional conditions not checked above/**Lista condiciones adicionales no marcadas

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My normal mode of transportation is**/Mi método normal de transportación es:

**[ ] Car**/Auto

**[ ] Bus/**Camion

**[ ] Walk**/Camina

**[ ] Ride with other**/Con otra persona

**[ ] Other** (Please list below) Otro método (explique por favor)

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HealthNet Icon

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HEALTHNET CABARRUS PATIENT AGREEMENT

Enrollment in HealthNet Cabarrus provides you a Medical Home for your ongoing health needs. 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-Health Cabarrus medical practices, 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.

You are enrolled for one year – you must recertify (or re-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.**

**When enrolled in HealthNet (Pink Card), you understand and agree: Initial \_\_\_\_\_\_\_\_\_\_\_**

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) 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.
5. **You** will take all 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 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.

**POSSIBLE REASON FOR TERMINATION OR DISQUALIFICATION**

**You** are eligible for Medicaid, Medicare, or have access to health insurance. **Initial \_\_\_\_\_\_\_\_\_\_**

**You** violate the exceeding missed appointments at your provider’s office (Or “No Shows”).

**You** miss one (1) appointment with a specialist or laboratory providing you HealthNet (Pink Card) services.

**You** use the Emergency Department without a life-threatening emergency, (and you will be responsible for the bill).

**You** are disrespecful or uncooperative with any clinic or medical practice staff this will result in 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 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.

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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. I understand that 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 I agree to allow Community Free Clinic to receive on my behalf the necessary health records, referrals, and prescriptions and to release them to healthcare providers participating in HealthNet Cabarrus Pink Card Program providing 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. I agree to these terms.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Full Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Community Free Clinic Representative Date

The Patient Agreement signature page is to be signed by HealthNet Cabarrus Pink Card Program enrolee 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.

**Health Screening**

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all your needs, but we will try and help as much as we can.

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Food** |  |  |
| 1. Within the past 12 months, did you worry that your food would run out before you got money to buy more? |  |  |
| 1. Within the past 12 months, did the food you bought just not last, and you didn’t have money to get more? |  |  |
| **Housing/ Utilities** |  |  |
| 1. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else’s home (i.e. couch-surfing)? |  |  |
| 1. Are you worried about losing your housing? |  |  |
| 1. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed? |  |  |
| **Transportation** |  |  |
| 1. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living? |  |  |
| **Interpersonal Safety** |  |  |
| 1. Do you feel physically or emotionally unsafe where you currently live? |  |  |
| 1. Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by anyone? |  |  |
| 1. Within the past 12 months, have you been humiliated or emotionally abused by anyone? |  |  |
| **Optional: Immediate Need** |  |  |
| 1. Are any of your needs urgent? For example, you don’t have food for tonight, you don’t have a place to sleep tonight, you are afraid you will get hurt if you go home today. |  |  |
| 1. Would you like help with any of the needs that you have identified? |  |  |