**HealthNet Cabarrus Pink Card Program Checklist**

For adults living in Cabarrus County that **are not eligible** for health insurance, Medicaid, or Medicare, or veterans' care.

| **Complete these documents** |
|---|
| Complete and sign the application – provided at Community Free Clinic or communityfreeclinic.org. |
| **Gather these documents** |
| **Proof of where you live in Cabarrus County- one of these examples:**<br>• NC Driver License or NC Photo Identification card with your current address **Or**<br>• Lease agreement if you rent; property/real-estate tax if you own your home **Or**<br>• 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 –**<br>• Pay stubs/Self-employment records/official employer letter (for the last 30 days)<br>• Disability Income – Current year benefit letter<br>• Social Security Income* - Current year benefit letter for any household members<br>If 65 years old and not eligible for Medicare – **a Medicare Denial letter is required.**<br>• Pension/Retirement – Current Benefit Letter<br>• 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**<br>**980-498-3059**<br>**Fax: 704-705-2741**<br>**Enrollment Hours: Monday-Thursday from 8:30am to 4:30pm**<br>**Online at communityfreeclinic.org** |

Application for the Pink Card Program

Name: ______________________________________________________________________

First Middle Maiden Last

Sex: ___M ___F ___Nonbinary Race_______ Age_____ Date of Birth: _______/______/____________

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

SSN/ITIN __________ _____ _________ Are you a Cabarrus County Resident? ◻ Yes ◻ No

Mailing Address ______________________________________________________________

City____________________________________________ Zip ______________________

**Best Contact Number ( )**_________________________

OK to Text? ____Yes ____No

Email: ____________________________________________________

Do you check your email often? ____Yes ____No

Emergency Contact Name/Relation_______________________________________________

Emergency Contact Phone Number __________________________________

How did you hear about the clinic? _____________________________________________

**HOUSEHOLD GROSS MONTHLY INCOME**

| | | | |
|---|---|---|---|
| Salary/wages* | ________ | Disability | _______ |
| Social Security | ________ | Worker's Comp | _______ |
| Unemployment | ________ | Self-employment | _______ |
| Pension | _______ | Other | _______ |

**Your Household Income must be at/or below 300% FPL (Federal Poverty Level)**

| # In Household | Monthly Income | Annual Income |
|---|---|---|
| (1) | $3,622 | $43,470 |
| (2) | $4,930 | $59,160 |
| (3) | $6,215 | $74,580 |
| (4) | $7,500 | $90,000 |
| (5) | $8,785 | $105,420 |

# Of adults in Household: _____

# of children (0-17) in Household _____

*Employer______________________________________________

**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.

Applicant Signature _______________________________________________________ Date ____________

I have received the HealthNet Cabarrus Pink Card Patient Agreement _________Initial Here

**Application for HealthNet Cabarrus Pink Card, 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 alergias 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

____________________
____________________
____________________
____________________
____________________

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

| | |
|---|---|
| ☐ 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 |

**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 CABARRUS PATIENT AGREEMENT

Enrollment in HealthNet Cabarrus provides you a Medical Home for your ongoing health needs. **HealthNet Cabarrus is NOT an insurance program, b**ut you MUST show your HealthNet Cabarrus enrollment/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 you access to health care for acute and chronic conditions and medications.

**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 go to your assigned HealthNet office instead of going to the hospital for non life-threatening care.
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. **We cannot see you for your appointment** if you are under the influence of alcohol or drugs.

**POSSIBLE REASON FOR DISCONTINUATION OF PROGRAM** **Initial ___________**

- **Eligibility** for Medicaid, Medicare, or have access to health insurance.
- **Miss** excessive appointments at your provider's office (Or "No Shows").
- **Miss** one (1) appointment with a specialist or laboratory providing you HealthNet Cabarrus services.
- **Visit** the Emergency Department without a life-threatening emergency instead of seeing your healthcare provider (and you will be responsible for the hopbill).
- **Disrespectful/uncooperative** with any clinic or medical practice staff
- **Failure** to report a change in residency, phone number, employment and/or financial resources within 10 days of change.
- **Falsifying** any information on any application or support documents.

**RENROLLMENT REQUIREMENTS**

You must reenroll 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 reminders to your home and phone when it is time to reenroll. **If your enrollment expires you will not have clinic or pharmacy services until you are reenrolled.**

**Privacy Policy**

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 enrollee and a Community Free Clinic Representative. This signature page will remain in the enrollee 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.

## THE COMMUNITY FREE CLINIC SERVICE AGREEMENT

- **You are expected to follow the plan of care.** The plan of care includes seeing your doctor as directed, getting lab work, x-rays, and other tests done as directed by your doctor, getting medications refills from your doctor ***within 7-14 days of needing refills (this is your responsibilit***y), and taking your medication as directed. **Please bring all medications with you to each appointment**.

- **If you are a patient at the Community Free Clinic.** Please keep your appointments or call prior to cancel or reschedule it. You can call 704-782-0650 Press option 4 for front office staff. If you are unable to make it and do not call you will be considered a NO SHOW. The policy is as follows for no shows: After three (3) NO SHOWS in a 12-month period your case will be referred to enrollment management for possible pink card discontinuation. If you are more than fifteen (15) minutes late for your appointment, you may be asked to reschedule. To maintain HIPAA laws and patient confidentiality, all patients must remain in the exam room unless directed to another area.

- **Medication Refills** The Community Free Clinic uses both samples from our Pharmacy as well as Med Assist to help patients get their medication. Free Clinic Pharmacy hours are posted on the pharmacy door, in our brochure, and on our website: www.commuityfreeclinic.org***. It is your responsibility to call your refills into the pharmacy prior to needing them.*** To make sure you have refills left, look at your medicine bottle. If you have questions, please contact our pharmacy directly 980-498-3058. If you need to reach someone with Med Assist, please call 704-943-9639.

- **Respectful behavior is expected at the Clinic.** You must silence your cell phone when entering the building. You will not be seen by the physician or served in the pharmacy if you are talking on your phone AND you may be asked to reschedule your appointment. Individuals who are verbally abusive, who use profanity or obscene language, are disruptive or appear to be intoxicated or under the influence of narcotics, will be asked to leave without service and can be discharged from receiving any services from the Clinic. Courteous and respectful treatment will be given to every patient, and our staff and volunteers should receive the same courteous treatment if you wish to continue to receive services.

I acknowledge that the above has been explained to me and I have been provided with a copy of this Service Agreement.

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Patient Signature Date

CFC 2022