Bernard Healthcare/Free Clinic of Franklin County

www.bernardhealthcare.com

Registration Application **Today's Date:**

1. Applicant Information

Is this your: ☐ 1st Time Application ☐ Renewal Application

Name: _____ _____ _____ SSN: _____
(Last Name) (First) (MI)

Are you? ☐ Male ☐ Female ☐ Transgender DOB: _____

Are you a Citizen or Permanent Legal Resident of the United States? ☐ Yes ☐ No

Address: _____ Town: _____ Zip: _____

Email: _____ How did you hear about us? _____

Home Phone: _____ Cell Phone: _____

Race: ☐ African –American ☐ Caucasian ☐ Hispanic/Latino ☐ Mixed ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower ☐ Partnered

Education: ☐ Elementary ☐ High School ☐ GED ☐ College ☐ Post Graduate

Emergency Contact: _____ Phone#: _____ Relationship:_____

2. Eligibility Information

Do you have Health Insurance? ☐ Yes ☐ No **Do you have Pharmacy Insurance?** ☐ Yes ☐ No

If you have Health Insurance what kind do you have? _____

Are you a Veteran? ☐ Yes ☐ No Are you Employed? ☐ Yes ☐ No

Do you receive Child Support ? ☐ Yes ☐ No

Do you receive Food Stamps? ☐ Yes ☐ No Did you file Tax Return last year? ☐ Yes ☐ No

Have you applied for Disability? ☐ Yes ☐ No Have you applied for Medicaid? ☐ Yes ☐ No

3. Household Members

Household = Spouse/Significant Other + Tax Dependents

Name (First Last)	Relationship	Age	Monthly Income	Income Source
1.			$	
2.			$	
3.			$	
4.			$	
5.			$	
6.			$	
Total in Household: _____			**Total Monthly Income**	
			* x 12 Months	
				%

4. Proof of Income

Attach all items below to this application (check box received)

- ☐ **PHOTO ID –** a copy of your drivers license or other photo identification
- ☐ **PAYSTUBS** – last/previous months paystubs of everyone working in the household OR a "Statement of Income from Employer" form from your employer with GROSS earnings for the previous month.
- ☐ **SELF-EMPLOYED** – complete /sign/date a "Self-Employed Statement" form **AND** make sure to include your Schedule C from your most recent tax return.
- ☐ **BENEFITS/INVESTMENTS/OTHER INCOME** – copies of any benefits checks and /or bank statements for all Investments, Social Security, Disability, Unemployment, Child Support, Alimony, Pensions, Interest payments, etc.
- ☐ **Tax Return – 1040 form** of your most recent tax return.
- ☐ **Zero Income** – applicants with Zero income must complete/sign/date a "Zero Income/"Food And/Or Shelter Letter" form. If you are living off of savings, you will need a copy of your bank or savings account statement.
- ☐ **Release of Info/Income Verification –** If receiving public assistance or you have no/limited income, then complete/sign/date the "Release of Info/Income Verification from the DSS" form.

Patients Signature: _____ Date: _____

Screeners Signature: _____ Date: _____

5. Patient Consent *(read and check boxes for consent)*

☐ I certify that all statements contained herein are true and correct and subject to investigation. I authorize the Bernard Healthcare Center/Free Clinic of Franklin County to share my protected health information with Rx Partnership and appropriate pharmaceutical companies, as necessary, to obtain my prescribed medication and to audit the performance of the clinic. The information used is to obtain medications as prescribed by the physician and for audit purposes. I do understand that I may revoke this authorization by written request.

As a healthcare provider, we required by 32. 1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

- If **one of our healthcare professionals**, workers, or volunteers should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV, the "AIDS" virus). A physician or other healthcare provider will tell you the result of the test.
- If **you should** be directly exposed to blood or body fluids of one of our healthcare professionals, workers or volunteers in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV, the "AIDS' virus). A physician or other healthcare provider will tell you and the person the result of the test.

☐ I have read and I understand the HIV consent statement

☐ I understand that my medications may be dispensed in non- child resistant containers

☐ I am requesting care at the Bernard Healthcare Center/Free Clinic of Franklin County. This request gives the Clinic staff and medical care provider's permission to perform physical exams and routine testing including collection of specimens for testing.

- All procedures will be explained to me prior to procedure. Procedures will be performed as directed by a physician. I may refuse any recommended treatment, testing or procedures.
- Any surgical procedure will be explained t me by Bernard Healthcare/Free Clinic of Franklin County physician and a new consent form signed including the date, medical provider and procedure to be performed.

BY SIGNING THIS DOCUMENT I AUTHORIZED TREATMENT BY THE BERNARD HEALTHCARE CENTER/FREE CLINIC OF FRANKLIN COUNTY STAFF OR PHYSICIAN.

In order to provide you with the best possible care the Bernard Healthcare Center/Free Clinic of Franklin County occasionally sends **Text messages, Emails and Phone messages** for reminders, follow ups and concerns etc. Choose your preferred method below:

☐ Appointment reminders (automatic) ☐ Voice Messages ☐ No contact

☐ Text Messages ☐ Email address _____

Patients Signature: _____ **Date:** _____

Screeners Signature: _____ **Date:** _____

5. Patient Guidelines

Bernard Healthcare Center/Free Clinic of Franklin County

General Rules for all Patients

☐ No Food or drink is allowed in the patient areas. Please put all trash in the trash cans.
☐ Appropriate behavior is expected at all times. Patient will remain in the waiting room until called. It is the parents responsible to monitor their children. No running, jumping or unsafe behavior is allowed. Inappropriate behavior by a patient, patient's family or friend, will result in patient being asked to leave. The incident will be reviewed to consider future service.
☐ Bernard Healthcare Center/Free Clinic of Franklin County will provide the best possible care for all patients.
☐ Bernard Healthcare Center/Free Clinic of Franklin County is not an emergency facility. If you have a medical emergency, go to the Hospital Emergency Room or call 911. **Bernard Healthcare Center/Free Clinic of Franklin County CANNOT PAY** for emergency room visits**.**
☐ Patients responsibility to inform Bernard Healthcare Center/Free Clinic of Franklin County about changes in their **Address, Phone Number, Insurance Status, and Income**.
☐ To be a **Active Patient** it is your responsibility to have all necessary documents required to **Re-register each Year** and you **must see doctor within 6 months** to continue getting refills on prescription(s).
☐ Prescription(s) and /or sample medication(s) can be ordered by our physician. Be aware there is a $3.00 processing/handling fee for each prescription and/or sample medication given. Any special ordered medications is your responsibility to pay. Fee is due at the time of your visit.
☐ Patient responsibility to re-order medication(s). All prescription refills must be called in before 3:00 p.m. on Wednesday in order to be picked up on Thursday of the same week. Anything called in after 3:00 p.m. Wednesday on the pharmacy line will no be filled until the next week. We **DO NOT DO ANY Auto Refills.**
☐ Prescription refills are available for pick up on Thursday after 1:00 p.m. until 4:30 p.m. Next available pick up day for refills is Monday. Bernard Healthcare Center/Free Clinic of Franklin County is open Monday through Thursday 8:00 a.m. through 4:30 p.m. We close each day from 12:00 p.m. through 1:00 p.m.
☐ Bernard Healthcare Center/Free Clinic of Franklin County does not provide second opinions.
☐ Bernard Healthcare Center/Free Clinic of Franklin County does not assume responsibility for charges incurred at a Specialist office or for certain special diagnostics. It is Patient responsibility to inquire about possible fees prior to seeing the physician/specialist.
☐ Patients who are diabetic are required to attend patient education programs to be eligible for reduced cost diabetic testing supplies.
☐ Appointments should be cancelled at least 24 hours prior to the appointment by calling (540) 489-7500. Please clearly leave your name, phone number and appointment date and time. If you miss 3 appointments without calling, you will be seen only in walk in clinic.
☐ **Donations:** Bernard Healthcare Center/Free Clinic of Franklin County depends on volunteers for their help. We depend on donations from the community in order to provide you with services. We ask that, when possible, make a donation to help keep Bernard Healthcare Center/Free Clinic of Franklin County going for you. ***Any amount is always appreciated. ***

Patient Signature: _____ **Date:** _____

Eligibility Screener: _____ **Date:** _____

Bernard Healthcare Center/Free Clinic of Franklin County

www. bernardhealthcare.com

ZERO Income - Self Declaration of No Income

I, _____, (print name) certify that I have NO employment and I do not have any source of income.

I am currently:

- ☐ Unemployed – looking for employment. Not receiving unemployment benefits.
- ☐ Seeking Disability. If so, when did you last apply _____? Have you been denied?_____
- ☐ Other _____

Signed: _____ Date: _____

Attached to my application I have a signed **Food & Shelter Letter when applicable (living with someone); otherwise, describe, living situation below (source of food/shelter, homeless, recently lost job, etc.)

_____

_____

OFFICE USE ONLY

I witness that this client has no documentation for **Proof of Income**.

Signed: _____ Date: _____

Bernard Healthcare Center/Free Clinic of Franklin County
www. bernardhealthcare.com

Food And/Or Shelter Letter

(complete this form if you have NO (or limited) income and are receiving help from friends or family.

This Statement is to be completed and signed by the person providing <u>you</u> Food and/or Shelter.

I, _____, (print name)
(Name of person providing food and/or shelter for applicant)

Provide (each Month): ☐ Food $ _____ ☐ Shelter $ _____ ☐ Money $_____

For _____, (print name)
(Name of person applying for services)

At this Address: _____

_____

If need be I (person providing food and/or shelter) can be contacted at the phone number below.

Phone Number: _____

Signed: _____ Date: _____
(Signature of person providing food and/or shelter for applicant)

OFFICE USE ONLY

This signed statement was received on _____(date)

Signed: _____ Date: _____
(signature of screener and date received).

Bernard Healthcare Center/Free Clinic of Franklin County

www. bernardhealthcare.com

Self Declaration of Income

(complete if new job and no income received at this time but expected)

Employment Information

I, _____, (print name) declare that I

Began working at _____, (employer/company) on

(first day of work if new job) _____. I earn $ _____ (hourly wage)

And work _____ (hours per week) or **Gross Salary** $ _____/(month)

Patients Commitment

I will bring paystubs covering one month (1 Month) of pay by _____ (date). I understand that failure to provide documentation of my income after the deadline could reduce future services, such as not receiving additional RxP/PAP medications, until Income documentation is on file.

Signature: _____

Date: _____

Office Use Only:

I witness that this applicant could not document income at initial registration.

Signature: _____Date: _____

Follow-up date: _____ (date income proof was provided)

Bernard Healthcare Center/Free Clinic of Franklin County

www. bernardhealthcare.com

Self Employed Statement of Income

(complete this form only if you are self-employed)

Business Information

Business Name: _____

Business Owners(s): _____

Business Address: _____

_____

Business Phone: _____

Brief description of Business: _____

Self Employed Gross Earnings

(For the business owner = what you paid yourself, NOT the business gross)
Need Past (3) Months. (Complete table below)

Month _____, 20_____	**Month _____, 20_____**	**Month _____, 20_____**
Week 1 $	Week 1 $	Week 1 $
Week 2 $	Week 2 $	Week 2 $
Week 3 $	Week 3 $	Week 3 $
Week 4 $	Week 4 $	Week 4 $
Week 5 $	Week 5 $	Week 5 $
Monthly Total $	**Monthly Total** $	**Monthly Total** $

Signature of Business Owner : _____Date: _____

Bernard Healthcare Center/Free Clinic of Franklin County

www. bernardhealthcare.com

Cash Income Declaration Form

(complete this form only if you receive **Cash Income**)

Cash Received from

Business/or Persons Name: _____

Business/or Owner(s): _____

Business/or Persons Address: _____

_____

Business/or Persons Phone: _____

Brief description of Business/or Persons Business: _____

_____

Applicants Cash Income

(For the applicant, CASH you received, NOT the amount after deductions IF ANY, but GROSS amount)
Need Past (3) Months. (Complete table below)

Month _____, 20_____	**Month _____, 20_____**	**Month _____, 20_____**
Week 1 $	Week 1 $	Week 1 $
Week 2 $	Week 2 $	Week 2 $
Week 3 $	Week 3 $	Week 3 $
Week 4 $	Week 4 $	Week 4 $
Week 5 $	Week 5 $	Week 5 $
Monthly Total $	**Monthly Total** $	**Monthly Total** $

Signature of Business Owner : _____Date: _____

Bernard Healthcare Center/Free Clinic of Franklin County
www. bernardhealthcare.com

Authorization for Release of Information/ Income Verification from DSS Public Assistance

Applicant's Name (Last, First, Middle Initial) _____

Date of Birth _____ SSN# _____ Home Phone _____

Address _____ Cell Phone _____

City, State, Zip _____ Email _____

County/City of Residence _____

I hereby authorize **The Department of Social Services** to release information from my file as indicated below to:

Bernard Healthcare Center/Free Clinic of Franklin County
P.O. Box 764, Rocky Mount, VA 24151
Phone# (540) 489-7500
Fax# (540) 489-7502

INFORMATION TO BE RELEASED:

- ☐ SNAP/TANF/WIC/Energy Assistance/etc.
- ☐ Most recent Income Verification

FOR OFFICE USE ONLY

Faxed ____/_____/_____

AUTHORIZATION:

I am applying for healthcare and medication assistance with Bernard Healthcare Center/Free Clinic of Franklin County and understand they need my income/public assistance verification from the Department of Social Services. Therefore, I authorize the above organizations to communicate freely between one another for the purpose of income/assistance verification. I understand this authorization will be valid for 12 months from the date signed. I understand that I may cancel this authorization by sending a written request for cancellation to Bernard Healthcare Center/Free Clinic of Franklin County, and the cancellation will take effect when Bernard Healthcare Center/Free Clinic of Franklin County, receives my written notice.

Signature: _____Date: _____

Bernard Healthcare Center/Free Clinic of Franklin County

www. bernardhealthcare.com

MEDICAID/INSURANCE DISCLAIMER

I choose to continue receiving my primary healthcare from Bernard Healthcare Center.

I understand that Bernard Healthcare Center will not bill Medicaid or any other health insurance, and that any changes I incur will not be applied to my deductible.

I understand that I, or my insurance, will be responsible for paying for any laboratory testing, diagnostic testing, or referrals to specialist made from the center to outside providers.

I agree to pay a facility fee to Bernard Healthcare Center at the time of each visit.

Date: _____

Name: _____

Signature: _____

☐ $5.00 Facility Fee + Lab Fee

☐ $10.00 Facility Fee + Lab Fee

☐ $15.00 Facility Fee + Lab Fee

FREE CLINIC OF FRANKLIN COUNTY DISCLAIMER

Whenever possible I agree to pay a facility fee to Bernard Healthcare Center/ Free Clinic of Franklin County at the time of each visit.

Date: _____

Name: _____

Signature: _____

☐ $25.00 Facility Fee + Lab Fee

☐ $35.00 Facility Fee + Lab Fee

☐ $55.00 Facility Fee + Lab Fee

☐ $75.00 Facility Fee + Lab Fee

☐ $95.00 Facility Fee + Lab Fee

Bernard Healthcare Center/Free Clinic of Franklin County
www. bernardhealthcare.com

Registration Guide

Please bring the following for your registration appointment:

- ✓ Proof of Identity
  - Photo ID
- ✓ Proof of residence
  - ✓ Driver's License or mail sent to you at your address
- ✓ Proof of income for everyone in the household
  - ✓ Pay stubs for 1 month for yourself and all family members who are employed
- ✓ Bank statements for all accounts
- ✓ Most recent Tax returns (1040)
- ✓ Insurance Cards
- ✓ If unemployed – Benefits letter
- ✓ If disabled or on Social Security – Benefits letter
- ✓ If receiving SNAP – Benefit letter with monthly amount for entire family

IMPORTANT NOTES:

- ➢ The clinic does not bill insurance. Patients are asked to pay a facilities fee at the time of service.
- ➢ If you choose not to present income information, you will be charged the full fee.
- ➢ Eligibility for low cost medications and free laboratory testing is dependent upon income and insurance status.

Registration must be completed annually to receive reduced fees. Please let the Clinic know when there are changes to any of the information listed above.

Call 540-489-7500 for a registration appointment.

Revised March 2019

Bernard Healthcare Center/Free Clinic of Franklin County
www. bernardhealthcare.com

Guia de registro

Por favor traiga lo siguiente para su cita de registro:

✓ Prueba de identidad

Identificación con foto

✓ Prueba de residenci

Licencia de conducir o correo enviado a su dirección

✓ Prueba de ingresos para todos en el hogar

talones de pago por 1 mes para usted y todos los miembros de la familia que están empleados

✓ Extractos bancarios para todas las cuentas

✓ Declaraciones de impuestos más recientes (1040)

✓ Tarjetas de seguro

Si está desempleado - Carta de beneficios

Si está discapacitado o en el Seguro Social - Carta de beneficios

Si recibe SNAP - Carta de beneficios con un monto mensual para toda la familia

NOTAS IMPORTANTES:

✓ La clínica no factura al seguro. Se les pide a los pacientes que paguen una tarifa de las instalaciones al momento del servicio.

✓ Si elige no presentar la información de ingresos, se le cobrará la tarifa completa.

✓ La elegibilidad para medicamentos de bajo costo y pruebas de laboratorio gratuitas depende de los ingresos y el estado del seguro.

El registro debe completarse anualmente para recibir tarifas reducidas.

Informe a la Clínica cuando haya cambios en la información mencionada anteriormente.
Llame al 540-489-7500 para una cita de registro.

Marcha 2019

Bernard Healthcare Center/Free Clinic of Franklin County
www. bernardhealthcare.com

FACILITIES FEE

UNINSURED*

Level 1 – <138% of poverty =	$5 (no lab fee)
Level 2 – 139-200% of poverty =	$10 +
Level 3 – 201-300% of poverty =	$15 +

(Fee waived for <300% of poverty if unable to pay.)

*Can get low cost medications in our pharmacy. + Lab test fees.

UNDER-INSURED/UNINSURED*

Level 4 – 0 – 200% of poverty (under-insured) =	$25 +
Level 5 – 201-300% of poverty (under-insured) =	$35 +
Level 6 – 301-400% of poverty (insured/uninsured) =	$55 +
Level 7 – 401-500% of poverty (insured/uninsured) =	$75 +
Level 8/Full Pay – income >500% of poverty *=	$95 +

(insured/uninsured) *or no income eligibility

(Fee must be paid prior to being seen.)

** Will have higher costs for medications in our pharmacy or will be given outside prescriptions.

Individuals of any income level/insurance status may come to the Bernard Healthcare Center; however, we do not bill any insurance and we require a facility fee payment based on income. Income documentation will not be collected on anyone willing to pay the full fee.

Revised March 2019

Bernard Healthcare Center/Free Clinic of Franklin County

www. bernardhealthcare.com

FACILITIES FEE

INSTALACIONES FEES

SIN ASEGURADO*

NIVEL 1 – <138% DE LA POBREZA	$ 5 (SIN CARGO DE LABORATORIO)
NIVEL 2 – 139-200% DE LA POBREZA	$ 10 +
NIVEL 3 – 201-300% DE LA POBREZA	$ 15 +

(CUOTA EXENTA POR <300% DE LA POBREZA SI NO SE PUEDE PAGAR.)

*PUEDE OBTENER MEDICAMENTOS DE BAJO COSTO EN NUESTRA FARMACIA. + TARIFAS DE PRUEBA DE LABORATORIO.

BAJO ASEGURADO/SIN ASEGURADO**

Nivel 4 – 0 – 200% de la pobreza (subasegurada) $ 25 +

Nivel 5 – 201-300% de la pobreza (subasegurada) - $35 +

Nivel 6 – 301-400% de la pobreza (asegurado/no asegurado) - $55 +

Nivel 7 – 401-500% de la pobreza (asegurado/no asegurado) - $75 +

Nivel 8/Pago Completo – ingresos >500% de la pobreza * $ 95 +

(asegurado/no asegurado) *o ninguna elegibilidad para ingresos

(La tarifa debe ser pagada antes de ser vista.)

** Tendrá costos más altos para medicamentos en nuestra farmacia o se le darán recetas fuera de.

Las personas con cualquier nivel de ingresos/estado de seguro pueden acudir al Bernard Healthcare Center; sin embargo, no facturamos ningún seguro y requerimos un pago de cuota de facilidad basado en los ingresos. La documentación de ingresos no se cobrará a nadie dispuesto a pagar la tarifa completa.

Marzo de 2019