# NEW HOPE CLINIC

Phone (910) 845-5333 Fax (910) 845-5366 www.newhopeclinicfree.org info@newhopeclinicfree.org

**Main Clinic:** 201 W. Boiling Spring Rd, Boiling Spring Lakes, NC 28461
Office hours: Monday-Wednesday 8 AM – 5 PM, Thursday 8 AM – 7 PM, Friday 8 AM – 4 PM

## SERVICES AVAILABLE

(All services are subject to change and depend on volunteer availability)

**MEDICAL CLINIC – Medical Diagnosis and Treatment:**

By appointment: Monday-Friday: 9AM-4 PM; Other hours as available

**PHARMACY** (for New Hope Clinic prescriptions):

**Tuesdays:** Drop off bottles or Call in by 12:00pm; Pick up **12:30pm-4:30pm**

**Thursdays**: Drop off bottles or Call in by 12:00pm; Pick up **2:00-7:00 PM** (or as directed)

**SPECIALTY CLINICS:** Need referral from New Hope Clinic provider.
Some available on site, others with community doctors

**DENTAL CLINIC** (Exams, extractions, referral for other services as available): Schedule with receptionist

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## New Hope Clinic – Shallotte

4600-10 Main St, Shallotte, NC 28470 (In Brunswick Family Assistance office – Big Lots shopping center)

**MEDICAL CLINIC** – By appointment - limited availability – call for details

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## HOW TO QUALIFY

Must be Brunswick County resident; No insurance, No Medicaid, No Medicare, No VA Medical; Income below 150% FPG

**Eligibility must be completed before services can be provided, renewed every year & when situation changes**

Interviews done on a Walk-in basis and seen in order of arrival at

New Hope Clinic, Boiling Spring Lakes: Mondays & Thursdays 9-4 PM; Shallotte: Wednesdays 1-4pm

Call if unable to come during these hours. Applications and documents may be mailed or faxed.

Please provide all of the following documents that apply to your household situation:

- Proof of Identity
- 2 recent Proofs of Residency
- Last year's Tax Return – Form 1040 and Schedules (as applicable)
- Recent paystubs (at least one month)
- Current Social Security or Disability Benefits Letter
- Current Unemployment Benefits Letter or Notice that benefits are exhausted
- Documents showing any other income
- If no income, letter of support from person or organization helping you
- VA benefits denial (if applicable)
- Medicaid denial - from Dept. of Social Services (if applicable)

Main Clinic and Mailing Address
201 W. Boiling Spring Rd.
Southport, NC 28461

(910) 845-5333 F-(910) -845-5366

NEW HOPE CLINIC

website: www.newhopeclinicfree.org

Satellite Clinic/Shallotte
4600-10 Main St.,
Shallotte, NC 28470

email: info@newhopeclinicfree.org

# Patient Enrollment Application

**Patient Information:**

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____/_____/_____ SSN / ITN: _____ Sex: ___ M ___ F ___Transgender

Address: (Street) _____ (Mailing - if different)_____

(City) _____ (State) ____(Zip)_____ (City) _____ (State) ____(Zip) _____

Home _____Cell _____Work _____ Phone: Preferred #: H / C / W

Email Address _____

Race: ____Asian/Pacific Islander ____Am. Indian ____White ____Black/African-American ____More than 1 race

Hispanic/Latino: ___ Y ___ N If yes, check one: ___ Puerto Rican ___ Mexican ___ Cuban ___ Other

Marital Status: ___ Married ___Separated ___Divorced ___Widowed ___Single ___Other

What is your housing arrangement? ___Rent ___Own ___Share expenses ___Homeless ___Other

Primary Language _____ Need Interpretation Services __Y__N

Veteran? _____ Y_____N How did you hear of Cape Fear HealthNet/New Hope Clinic? _____

Do you work? No____ Full time____ Part time____ Self Employed____ Retired____

Are you a student? Y___ N___ If yes, Full time____ Part time____

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**Tax Information**

•Did you file taxes last year? .....___ Y ___ N Did someone else in your house file taxes.....___ Y ___ N

If yes, what is their relationship to you?_____

**Insurance/Benefit Information:**

• Do you have Medicaid, Medicare, VA Benefits or any other health insurance?..... ___ Y ___ N

If yes, what do you have? _____

•Are you eligible for work-based insurance through your employer or your spouse's employer? ..... ___ Y ___ N

**Medical/Dental Information:**

•Where do you go when you are sick? _____

•Give a brief description of your current medical/dental problems: _____

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**I hereby verify that the information I have given on this application is true and correct. I understand I must provide the information requested to determine my eligibility. WITHOUT ID AND INCOME VERIFICATION, CAPE FEAR HEALTHNET (CFHN) AND NEW HOPE CLINIC (NHC) WILL NOT BE ABLE TO SEND ME FOR OR PROVIDE HEALTH CARE OR MEDICATIONS. I give permission to CFHN or NHC to contact employers and references I have provided to verify information if needed. I understand that providing false information may disqualify me from any present or future assistance with CFHN or NHC. I will report any changes in income, resources and/or family composition within 7 days of change. In the case of ineligibility, I will not reapply for 90 days without extenuating circumstances.**

**Patient's Signature:** _____ **Date:** _____

**NHC/CFHN Staff Signature:** _____ **Date:** _____

Proof of Identity □ Proof of Residence □ All Proofs of Income □ Tax Return/4506-T □

Monthly Income verified against Federal Poverty Guidelines. □

**# in Household:**_____ **Gross Monthly Income: $**_____ **FPL:** _____%

Does this applicant qualify for New Hope Clinic services? Yes □ No □ If no, reason: _____

If no, alternatives offered/referred to: _____

Determination made by: (clerk signature)_____ Date:_____

NHC Pt ID_____ Athena#_____ NHC DB_____ CFHN_____ NHRMC_____

New Hanover Regional Medical Center

Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

DOB: _____ MR#: _____

Acct#: _____

## FINANCIAL AID APPLICATION

**Patient Name:** _____ **Social Security Number:** _____

**Home Address:** _____ **Home Phone #:** _____ **Cell #:** _____

**City, State, Zip:** _____ **Spouse's/Other Employer:** _____

**Patient's Employer:** _____ **Patient's Date of Birth:** _____

**Please list below the additional people living in your home, if needed, please include a separate sheet.**

| | Name | Social Security Number | Date Of Birth | Relationship to Patient |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

- Do you have health insurance? If yes, name of health insurance carrier. ___ Y ___ N _____
- Have you applied for insurance through the Health Insurance Marketplace? If yes, submit a copy of the decision statement and enter the date of application. ___ Y ___ N Date of application _____
- Have you applied for Medicaid? If yes, submit a copy of the decision letter. ___ Y ___ N
- Is this visit related to a job-related injury? ___ Y ___ N
- Is this visit related to a motor vehicle crash? ___ Y ___ N

➢ **If you have no income, submit a letter of support. The person who provides your support (food/shelter) must sign the letter.**

➢ **If unemployed, last date of employment: _____. Will you receive unemployment? Please provide an ESC statement reflecting status of benefits.**

## INCOME

| **Patient:** | | **Spouse/Other Income:** | |
|---|---|---|---|
| Wages/Salaries/Tips | $_____/Month | Wages/Salaries/Tips | $_____/Month |
| Unemployment/Compensation | $_____/Month | Unemployment/Compensation | $_____/Month |
| Social Security / SSI Benefits | $_____/Month | Social Security / SSI Benefits | $_____/Month |
| Pension/Retirement/VA | $_____/Month | Pension/Retirement/VA | $_____/Month |
| Alimony / Child Support | $_____/Month | Alimony / Child Support | $_____/Month |
| Other: _____ | $_____/Month | Other: _____ | $_____/Month |

## ASSETS

| | | | | | |
|---|---|---|---|---|---|
| Do you own your home | ___ Y | ___ N | If yes, payment amount $ _____ /Month | Home value $ _____ | |
| Do you rent your home | ___ Y | ___ N | Amount: $ _____/Month | | |
| Checking Account | ___ Y | ___ N | Balance: $ _____ | | |
| Savings Account | ___ Y | ___ N | Balance: $ _____ | | |
| Stocks/Bonds/CDs | ___ Y | ___ N | Value: $ _____ | | |
| IRA/401K/403B | ___ Y | ___ N | Value: $ _____ | | |
| Automobile 1 | ___ Y | ___ N | Value: $ _____ | Year/Make/Model: _____ | |
| Automobile 2 | ___ Y | ___ N | Value: $ _____ | Year/Make/Model: _____ | |
| Boat/Motorcycle/RV | ___ Y | ___ N | Value: $ _____ | Description: _____ | |
| Other: _____ | | | Value: $ _____ | Description: _____ | |
| Other Real Estate | ___ Y | ___ N | Value: $ _____ | Payment $ _____ /Month | |
| | | | | Rental Income $ _____ /Month | |

Address _____

**Turn this page over to complete other side**

**PART OF THE PERMANENT MEDICAL RECORD**

New Hanover Regional Medical Center

Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

DOB: _____ MR#: _____

Acct#: _____

## FINANCIAL AID APPLICATION

### HOUSEHOLD EXPENSES (That YOU are responsible for)

| | | | |
|---|---|---|---|
| Food: | $_____/Month | Auto Payment 1: | $_____/Month |
| Heating/Electric: | $_____/Month | Auto Payment 2: | $_____/Month |
| Phone/Cell: | $_____/Month | Auto Insurance: | $_____/Month |
| Water/Sewer/Trash: | $_____/Month | Auto Gas/Maintenance: | $_____/Month |
| Child Care/Child Support: | $_____/Month | Property Taxes/Homeowners Ins: | $_____/Month |
| Cable/Satellite/Internet: | $_____/Month | Credit Cards: | $_____/Month |
| Doctors/Medications: | $_____/Month | Loans: _____ | $_____/Month |
| Health/Life/Dental Ins: | $_____/Month | Other: _____ | $_____/Month |

Please describe your hardship:

_____

_____

_____

_____

**I understand that this application is valid only for the individual applying. A separate application is required for any additional person listed in the household that has a current account with NHRMC.**

**INITIAL** _____ **DATE** _____

**I understand that this application is only for the Hospital bill. This does not cover the separate bills I will receive from the physicians/doctors that may include the ER doctor, Radiologist, Surgeon, Rehabilitation Doctor, Anesthesiologist, Pathologist, etc. when applicable.**

**INITIAL** _____ **DATE** _____

I certify that the above statements are true and correct to the best of my knowledge and belief. I understand that the Hospital will require PROOF of INCOME (credit report, tax returns, paycheck stubs, disability determination, etc.). I will make applications for any assistance (Medicaid, Medicare, Disability, Insurance, etc.) which may be available for payment of my hospital charges and that I will take any action reasonably necessary to obtain such assistance and will assign or pay to the Hospital the amount recovered for hospital charges. Further, I understand that charity care is not considered an alternative option to other assistance programs. I understand that this application is made for the Hospital to determine my eligibility to have the Hospital accounts transferred to the Financial Aid program by the criteria established.

I authorize New Hanover Regional Medical Center to contact employers, institutions and references of this application to verify its accuracy and to check my credit history to substantiate its validity. I understand that any false information or refusal to supply information will void my request for Financial Aid. I understand that the Hospital may evaluate my financial ability again and take whatever action becomes appropriate. If it is determined that I am eligible to receive Financial Aid or waiver of payment, it is my responsibility to notify the hospital of financial status changes. If you are claimed as a dependent by someone other than yourself, their income and signature will be required to process your application.

_____ _____

Date of Request Applicant's Signature

_____ _____

Application Taken By Signature of Applicant's Spouse/Parent/Other

**DO NOT WRITE BELOW THIS LINE**

___ Approved F/A ___ Approved One-Time ___ Incomplete

___ Approved E/E/H ___ Referred to Management ___ Denied

Comments:

_____

_____

_____

_____ _____

Patient Financial Services Representative Date

**PART OF THE PERMANENT MEDICAL RECORD**

*2068*

**Financial Aid Application**



BO-063 (1/2014 v1)

201 W. Boiling Spring Rd.
Southport, NC 28461
www.newhopeclinicfree.org

# NEW HOPE CLINIC

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info@newhopeclinicfree.org

## Patient Agreement / Acknowledgement of Receipt of Privacy Practices

PATIENT NAME:_____ DATE OF BIRTH:_____

I acknowledge and fully agree to the following matters: (initial by each item)

____1. I understand that New Hope Clinic is an independently operated charitable organization that is funded through grants and individual donations. I understand that health care services provided at the New Hope Clinic, Inc. are subject to change due to availability of funding and staff. Services available at New Hope Clinic will be provided free of charge, including visits with our healthcare providers, medications from our limited pharmacy, and tests performed on site. In the event that unavailable services are prescribed, New Hope Clinic will try to arrange for services to be provided a no or reduced cost. I understand that payment for these services is my responsibility and New Hope Clinic is not able to pay for these outside costs. These outside costs may include, but are not limited to, some medications, testing, specialty appointments, and emergency treatment.

____2. Good communication between patients and the Clinic is the key to better health & outcomes. New Hope Clinic is committed to providing patients the highest quality healthcare. This can best be accomplished by a clear understanding about the Clinic's responsibilities to patients, and the rights and responsibilities of a Clinic patient. I confirm that I have received the New Hope Clinic, Inc. Patient Handbook dated 10/9/2019 and am responsible for following the guidelines in the handbook. If I do not follow these guidelines, I may be terminated from NHC.

____3. **I understand that New Hope Clinic will help me manage my healthcare in many ways, but will not prescribe controlled substances, such as narcotics for pain or benzodiazepines for anxiety, and no controlled substances are kept at the Clinic. I understand that repeated requests for controlled substances will result in dismissal from New Hope Clinic.**

____4. I, (the patient) am ____ years of age and I am either able to read this, or I have had this document read to me by the witness/reader whose name appears below.

**Privacy Practices:** It is required that we protect the privacy of health information of our patients. You may request that only certain individuals (usually close family or friends) be given information about your health, treatment or other personal information. You can also request how New Hope Clinic communicates information to you.

Our clinic participates in the NC Health Information Exchange Authority to share your health information with other medical providers to assist them in making critical medical decisions for you. You have the right to opt out of having your information shared between providers through NC HealthConnex. If you choose to opt out, please ask for the Patient Opt Out Form.

**We need to have a way to contact you or leave a message during day time hours.** Please contact me in the following manner:

Home Phone #: _____ It is OK to leave detailed information on voice mail? Y___ N ___

It is OK to leave detailed information with a person? Y___ N___ Name of individuals:_____

Cell Phone #: _____ Is it OK to leave detailed information on voice mail? Y___ N___

**May automated/reminder calls be made to your cell phone? Yes____ No ____

**May we send you a text messages? Yes____ No ____

Work Phone #: _____ Is it OK to leave a detailed message on personal voice mail? Y___ N___

**Which phone do you want us to call first? Home____ Cell ____ Work ____

Email: **May we email you? Yes___ No____ Email address:_____

Emergency Contact Name:_____ Relationship:_____#: _____

Is it OK to leave a message with someone or on voicemail? Y___ N___

If the above are answered NO, a message will be left only stating that our office called and a name and call back number will be left. All correspondence mailed to you will be in a sealed envelope addressed only to you.

I authorize New Hope Clinic, Inc.'s staff to discuss my Protected Health Information with the following individuals:

| Name (Please Print) | Relationship to Patient |
|---|---|
| _____ | _____ |
| _____ | _____ |

I acknowledge that I have been given the opportunity to read New Hope Clinic, Inc.'s Notice of Privacy Practices and understand that the above will remain in effect until revised by me.

_____ _____ _____ _____

Date Time Patient/Legal Guardian Signature Printed Name

_____ _____ _____ _____

Date Time Reader/Witness Signature Printed Name

Cape Fear HealthNet
Bridging the Gap for the Uninsured

# Welcome to Cape Fear HealthNet!

## It is our goal at Cape Fear HealthNet to facilitate your access to health care.

Cape Fear HealthNet (CFHN) is a system of care for uninsured people with limited income and resources who live in Brunswick, Columbus, New Hanover or Pender Counties. CFHN connects uninsured adults to primary and specialty care providers. CFHN's network of health care providers and organizations are committed to helping you get well and stay well. In many cases, the professionals providing care to you are volunteers. CFHN is not a government program, health insurance or payment source. CFHN cannot guarantee the availability of any service or provider. Programs and services are subject to change. By signing below, you agree to the Member Rights and Responsibilities explained below.

### CFHN Members have the right to:

- Receive considerate, respectful and compassionate care by licensed medical professionals, volunteering to serve you, regardless of age, gender, race, national origin, religion, sexual orientation or disabilities.
- Know the cost of care in advance to the extent possible. Some services are donated by volunteers, but you may have a small co-pay for services and/or medication or pay on a sliding scale based on your income. It is your responsibility to understand what your commitment is, ask questions about that commitment and to honor it.
- Expect that all communications and records pertaining to your care will be treated as confidential except as required by law. Medical records are kept confidential per HIPAA regulations. We do collect general information to report to our funders, for example: county of residence and services used.
- Receive complete information regarding your condition, how to manage it, benefits and risks of completing the treatment or not, and expected outcome of the condition after management.
- Participate fully in decisions about your care and treatment and involve family and/or friends you designate to participate in decisions about your care.

### CFHN Members have the responsibility to:

- Provide accurate and complete eligibility information and report any changes to CFHN immediately (insurance, pay raise, new job, change in the number of household members, etc).
- Attend all appointments on time. If you must miss an appointment, including appointments with CFHN staff, you must reschedule as required by the individual practice. Failure to provide the required advance notice for a specialty care appointment may result in suspension from CFHN services. Please contact your Enrollment and Eligibility Specialist with any transportation issues before your appointment.
- Present your CFHN membership card and a photo identification card at all health care appointments. Your membership card cannot be used by any other person. This card is not valid if the signature under the seal is tampered with. If a family member or friend needs assistance they should contact CFHN to be screened and if eligible issued their own card.
- Understand that your membership is generally for a full year from enrollment date. However, from time to time, we might issue a shorter-term membership for people likely to receive Medicaid or other services in the near future. Be sure to contact your Enrollment and Eligibility Specialist one month before your membership will end so that you can be recertified. We want

to help you as much as we can, however, if you do not recertify in time, your membership will be terminated.

- Be respectful of the CFHN staff, your health care providers and other people when you are at any network provider.
- Know and abide by the rules and regulations of each place you receive services.
- Pay for services that require a co-pay at the time they are received.
- If you are referred to a specialty care provider, the provider will contact you to make the appointment. Please be sure you have voicemail available so they can leave you a message if necessary. The volunteer physicians have agreed to only see patients that are referred through your CFHN primary care provider. If you make and keep an appointment outside of this process, you will be responsible for the bill.
- Contact volunteer physician offices only to reschedule appointments or if the physician asked you to call. All other contact must be through your primary care provider.
- **Please contact CFHN with any questions concerning your enrollment or specialty care referrals.**

Thank you for your commitment to your good health.

Member Signature _____

Date_____

Enrollment Specialist _____

Date_____

Updated: 5/5/20

Cape Fear HealthNet
Bridging the Gap for the Uninsured

Wilmington, NC 28401
Phone: (910) 399-2751

1601 Doctors Circle

Fax: (910) 399-2756

Patient Name: _____ Date: ____/____/____

Date of Birth: ____/____/____

## Authorization for Use and Disclosure of Protected Health Information

1.**Disclosure Authorized**. I authorize all of my health care providers, health plans, and case management service providers, including physicians, nurses, hospitals, nursing homes, the Medicaid program, private health insurers, Community Care of the Lower Cape Fear and all other persons and entities who have provided, or may be providing me with any type of health care, health insurance or case management services, to disclose all of my protected health information to Cape Fear HealthNet ("CFHN"), and its partners: **Cape Fear Clinic, Good Shepherd Center, MedNorth, New Hope Clinic, New Hanover Regional Medical Center, Black River Family Practice, New Hanover Medical Group, Christ Community Clinic and Coastal Horizons Health with the exception of psychotherapy notes.** I further authorize CFHN and partners to share any protected health care information it obtains from the above health care providers, health plans, health insurers and case management service providers to other health care providers, health plans, health insurers, and case management service providers and to all other persons and entities who may be contacted for a health care referral, and also to appropriate social service agencies. I also authorize CFHN and partners to verify financial information with appropriate service providers and any current or previous employers as is necessary to complete eligibility verification. CFHN staff or partner may also discuss my case with the following persons:

| Name | Relationship | Phone Number |
|---|---|---|
| Name | Relationship | Phone Number |

CFHN or partner staff may leave a message on my answering machine/voice mail at home: Y / N
CFHN or partner staff may leave a message on my answering machine/voice mail at work: Y / N
CFHN or partner staff may leave a message with someone or on the answering machine/voice mail at my emergency contact number: Y / N

2. **Purpose of Authorization.** The purpose of this authorization is to enable Cape Fear HealthNet and partners to assist me in managing my medical condition and connect me with other community resources, partners and medical providers, for services which I might need.
3. **Expiration Date.** This authorization will expire one (1) year from the above date unless revoked by me prior to that date. This authorization may be revoked by me in writing at any time.
4. **Required Disclosures.** I understand that any information used or disclosed under this authorization may be subject to re-disclosure and may no longer be protected under federal privacy rules.

**I understand that my health care providers and health benefit plans cannot refuse to treat me or deny me benefits simply because I refuse to sign this authorization.**

_____ ____/____/____
Patient Signature Date
Print Name: _____

_____ ____/____/____
Person Signing on Behalf of Patient Date
Print Name: _____

_____ ____/____/____
Witness Signature Date
Print Name: _____