MOORE FREE & CHARITABLE CLINIC
Healing Hands. Caring Hearts.™

211 Trimble Plant Rd. Suite C
Southern Pines, NC 28387
Phone: 910.246.5333
Fax: 910.246.5330

MFCC Documentation Checklist

Participant Eligibility

Moore Free and Charitable Clinic (MFCC) is a "not for profit" health care facility which is dedicated to providing health care to the limited income uninsured. It is important to read and understand the eligibility requirements and to also ensure that you bring the appropriate documentation to your enrollment appointment.

To recertify or become a new patient of MFCC you **MUST**:

- Be a resident of Moore County
- Be uninsured
- Meet income requirement.

To schedule an appointment: Call (910)246-5333 ext. 205 or ext. 204

2019
Federal Poverty Table
 # In house – Income
1 - $24, 980
2 - $33, 820
3 - $ 42, 660
4 - $51, 500
5 - $60, 340
6 - $ 69,180

Please bring *all* of the following to your enrollment appointment:

1. ☐ **Completed Enrollment Packet**

2. ☐ **Most recent (signed) Complete Federal Tax Return**
   a. If you DID NOT file taxes, please fill out form 4506T ; **or**
   b. If you did file we will need a copy of **Form 8695**- Health Coverage Exemption
   c. If someone has claimed you as a dependent, you will need to bring *their* tax return; **or**
   d. If your spouse filed taxes, you will need to bring *their* tax return; **or**
   e. If you were self-employed at any time in the last year you will need a *Schedule C*

3. ☐ **Copy of Valid Photo ID**
   a. Driver's License; **or**
   b. State Issued ID; **or**
   c. Government Issued ID

4. ☐ **Proof of Address** (dated for the current year and not more than 2 months old)
   a. Utility Bill (electric, gas, phone etc.) showing "service address";* **or**
   b. Medical Bill **or**
   c. Other: (County Tax Bill; **or** Rental contract)
   d. If Not in Your Name, the person who's name it is in needs to complete the letter of support (page 5).

   ** The address on your proof of residency needs to match the physical address you are providing!*

5. ☐ ***Income Verification- for your spouse and yourself – see Page**

★ **IMPORTANT NOTE:** Many Pharmaceutical Assistance Programs **REQUIRE** a Medicaid Denial letter. Should that become necessary, it is **YOUR** responsibility to furnish it in a timely manner in order to receive your medicine.

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Patient Information Sheet

☐ New Enrollment / Certification Chart #:_____ Date: _____

Name (Print): _____ Home Phone: _____
Date of Birth: _____ Cell Phone: _____
Social Security #: _____ Email Address: _____
Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email Would you like to receive text alerts? ☐ Yes ☐ No

Physical Address: _____
Mailing Address: _____

List all people who contribute or are dependent on your income, including yourself. Include full names and dates of birth.

Name	***Date of Birth***	***Relationship***	***Employment Status***
1.			
2.			
3.			
4.			
5.			

Do you have health insurance? ☐ Yes ☐ No
If yes, which of the following: ☐ Medicare ☐ Medicaid ☐ Family Planning ☐ Other_____

How did you hear about the clinic?
☐ Hospital ☐ ER ☐ DSS ☐ Transition Care Clinic (TCC) ☐ Patient ☐ Other_____

Marital Status:
☐Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Race:
☐ White ☐ African American ☐ Hispanic ☐ American Indian ☐ Asian ☐ Other_____

Ethnicity:

☐ Central American ☐ Cuban ☐ Dominican ☐ Hispanic/Latino/Spanish

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Income Verification Worksheet

Are you currently employed? ☐ Yes ☐ No (NOTE: Please consider all work, including part-time or "side" jobs.)

Name of Employer: _____

How much do you earn per hour: _____ How many hours do you work per week: _____

Is your spouse employed? ☐ Yes ☐ No

Name of Employer: _____

How much do they earn per hour: _____ How many hours do they work per week: _____

Please estimate monthly income amounts for any of the following that apply to you or your spouse:

Employment Income: $_____ Did you file current taxes? ☐ Yes ☐ No
Please Include 60 consecutive Days of Paystubs For Self and Spouse

Unemployment Income: $_____ When did you last file? _____

Have you been claimed this tax year? **If yes, bring tax return.* ☐ Yes ☐ No

Social Security: $_____
***Current Year Benefit Statement For Self and/or Spouse**
**** Bring Award Letter if for Self**

Disability:	$	Notes:
VA Benefits:	$	
Child Support	$	
Other:	$	
TOTAL MONTHLY INCOME:	$	

I authorize Moore Free & Charitable Clinic to contact the Department of Social Services, Employment Security Commission, or any other agency or source for the specific purpose of obtaining and confirming information pertinent to my request for assistance from time to time. I understand that everything in this interview and in the future will be kept in confidence except as stated above.
I hereby state that I have no insurance and have not enrolled in the Affordable Care Act (ACA)
Your signature confirms the information you have provided to be true and correct to the best of your knowledge. Information provided will be confirmed.

Patient Signature_____ **Date**_____

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Income Verification Documents

Based on the information you provided on the previous page, identify which of the following best describes your situation and bring all of the listed documents to your certification appointment.

1. If you are **EMPLOYED**:
   - Last 2 months of *your* most recent paycheck stubs, dated within the last 60 days*
   - If you are paid cash, or paid irregularly:
     i. Signed statement by someone who has paid you for work in the past 30 days.

2. If your spouse is **EMPLOYED**:
   - Last 2 months of *their* most recent paycheck stubs, dated within the last 60 days *

3. If you are **UNEMPLOYED** and have $0 income:
   - Fill out "Letter of Support" on pg.5 for anyone who is supporting you financially
   - Zero Income Statement

4. If you are **UNEMPLOYED** but your spouse *IS* employed:
   - Last 2 months of *their* most recent paycheck stubs, dated within the last 60 days

5. If you or your spouse receive any **BENEFITS**:
   a. Bring *all* of the following that apply:*
      - Retirement
      - Disability
      - Unemployment
      - Supplemental Security Income
      - Social Security New Benefit letter **(Must be for the current year)**
      - Award Letter from Social Security Administration if patient is one receiving Social Security Benefits

   *Must be from the agency, examples of what these letters look like can be provided by the MFCC office.

***** If either you or your spouse is not working that party needs to sign a Zero Income Statement.**

If you have any questions about these materials, please call the clinic before your appointment at **(910) 246-5333 ext. 205 or ext. 204.**

Note: If you are a current patient, your recertification date with MFCC and with various medication assistance programs may not be the same. In this case, we may have to contact you in the future for more current documents.

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Letter of Support

If anyone supports you financially, or is providing you a place to live, please have them complete this page. This is for documentation only, we will never ask them to be responsible for your medical costs or give their information to a third party.

I am providing support for _____ as indicated below:
(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.

Please enter an approximate dollar amount 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:	$_____	☐ Weekly	☐ Monthly
Housing	$_____	☐ Weekly	☐ Monthly
Utilities	$_____	☐ Weekly	☐ Monthly
Cash	$_____	☐ Weekly	☐ Monthly
Other: (explain below)	$_____	☐ Weekly	☐ Monthly

Other support: _____.

Supporter's Name (Print): _____ Contact Number: _____

Physical Address: _____

Supporter's Name (Sign): _____ Date: _____

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Patient Agreement

1. **Moore Free & Charitable Clinic (MFCC)** is a not-for-profit organization that provides primary health care to eligible patients. MFCC is not a government agency, and is supported primarily through private donations, grants and proceeds from fundraising events. Many of our patients make donations to MFCC as they are able, and we welcome them.

2. **Non-Discrimination:** MFCC does not deny services or enrollment based on a person's race, color, sex, gender orientation or expression, national origin, disability, religion or financial status.

3. **Fees:** When you are enrolled, you will be informed whether you will be required to pay a fee, according to a sliding scale based on your income. MFCC charges a fee if you fail to show up for an appointment and do not cancel in advance. Patients who are referred for specialty care may be required to apply to other charity care programs that require discounted payments, such as FirstHealth of the Carolinas and UNC Health Care. MFCC provides health care at low or no fees thanks to the generosity of our donors and our volunteers. We hope you will take the opportunity to express appreciation for this service to our providers, staff and volunteers.

4. **Hours of Operation:** Monday, Wednesday and Thursday: 8:30 am – 5 pm.
   Alternate Tuesdays: 8:30 am – 7 pm.
   Friday: 8:30 am – 3 pm
   MFCC is closed daily from 12:00 pm – 1:15 pm.

5. **Patient Responsibility:** You are a vital part of the health care plan that will be put in place to help you achieve wellness; therefore, **you are expected to be an active participant in your own care**. This means you are responsible for arriving to your appointments on time, taking medicines prescribed to you, and notifying MFCC if there are any changes in your health. If you need medication refills from your local pharmacy, you must contact them 5-7 days before you run out, so they can send us a medication refill request. If you receive medications through Patient Assistance Programs and pick your medication up at MFCC, you must contact the clinic 30 days before you run out so that we may send the refill request to the company.

6. **Policies:** Please note the following important policies:
   a. Financial verification documents are required for enrollment with MFCC and medication assistance programs. If we do not get them in a timely manner, you will NOT be eligible for services.
   b. No-shows: If you are 10 minutes late or more for your appointment, you will NOT be seen and will have to reschedule.
      i. First no-show for ANY appointment: $10 fee
      ii. Second no-show: Possible discharge from MFCC for 1 year, after which you may re-apply to be a patient of MFCC.
   c. Appointment Cancellations: Call **at least 48 hours before** your appointment time to cancel and reschedule. A late cancellation is considered a no-show and the no-show policy will apply. *Exceptions be made in case of emergency, at MFCC's sole discretion.*
   d. Appointment reminders: You will be called or texted with an appointment reminder. It is your responsibility to provide MFCC with your updated contact information as soon as possible.

7. **Behavior:** Inappropriate conduct by a patient or family member toward any MFCC provider, nurse, staff, patient or volunteer will be grounds for immediate discharge from MFCC. Inappropriate conduct includes but is not limited to rude, disruptive behavior, being under the influence of alcohol or other substances, smoking, bad language and harassment. Also, intentional misrepresentations and misuse of MFCC services also may be grounds for discharge.

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8. **Children:** Unfortunately, we do not offer medical services for children. Please avoid bringing children to your appointments. If you have no other option but to bring a child with you, you must also bring a responsible adult to watch them during the office visit. Children are NOT permitted into the exam rooms and must remain in the lobby under supervision.

The patient acknowledges the above expectations and agrees to the following:

- I agree to keep appointments for labs, X-rays and specialty referrals and I understand that if I miss my appointment without at least 48 hours' notice (excluding documented emergency), then I will be charged a fee or may be discharged from Moore Free & Charitable Clinic (MFCC).
- I acknowledge that patients are not guaranteed nor are they entitled to specific services.
- I agree that if I do not provide documents for eligibility screening or recertification as required, I will be made inactive and will have to reapply for enrollment.
- I understand that the medications provided by MFCC may not be in childproof containers. I agree to keep all medications out of reach of children.
- I agree to call MFCC at least 30 days before running out of medication to request a refill if it is a medication I pick up at MFCC.
- I understand MFCC often prescribes generic medications which are available at my local pharmacy at a very low cost, and that I am responsible for purchasing my medications and requesting a refill 5-7 days in advance of running out as part of my commitment to self-care.
- I give consent to MFCC to send my medical records to other providers when necessary for referral purposes.
- I understand that inappropriate conduct may result in termination of all MFCC services.
- I agree that if I begin to receive Medicaid, Medicare, and any other insurance coverage or if I have a change in household income, I will immediately notify MFCC.

IF I DO NOT UNDERSTAND ANY PART OF THIS AGREEMENT I WILL ASK FOR CLARIFICATION.

I have read and understand the MFCC Application and Patient Agreement and accept the terms. I have received a copy of the Notice of Privacy Practices (HIPAA).

Patient Name: _____
Print

Signature: **X**_____ Date: _____