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

February 4, 2025

Patient
113 Sunburst
Aberdeen, NC 28315

Dear Patient,

Thank you for your interest Moore Free & Charitable Clinic.

Moore Free & Charitable Clinic provides the following healthcare services for uninsured residents of Moore County with limited income of 300% or less of the Federal Poverty Level:

- Primary care for chronic illness
- Care for short term illness and minor injury
- Specialty care by referral
- Laboratory and radiology services
- Behavioral health services
- Limited dental care
- Group medical and nutritional education

Please find attached, the New Patient enrollment packet. This packet provides most of the information we need to complete your enrollment with the clinic. Please review carefully and complete the front and back of each document at your earliest convenience. Your enrollment appointment is schedule for _____.

Your health is important to us. Please don't hesitate to call should you have any questions.

Sincerely,

Esther Ross
eross@moorefreecare.org
Enrollment Specialist
910-246-5333 Ext 205
Fax: 910-246-5331

Christina Sanford
csanford@moorefreecare.org
Enrollment Specialist
910-246-5333 Ext 204

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 organization that provides primary health and dental care to the limited income uninsured residents of Moore County. 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.

To recertify or become a new patient of MFCC you **need to be**:

- Be a resident of Moore County
- Be uninsured
- Meet income requirement. (See table to the right)

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

2025 Federal Poverty Level Table 300% household – Income
1 - $46,950
2 - $63,450
3 - $79,950
4 - $96,450
5 - $112,945
6 - $129,450

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 *his or her* tax return; **or**
   d. If your spouse filed taxes, you will need to bring *their* tax return; **or**
   e. If you were self-employed and filed a tax return 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 Residency** (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 the bill is Not in Your Name, the person who's name it is in needs to complete the letter of support.

   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 Income Verification Documents**

6. ☐ **Self – Employed or living off saving, bank statements required (dated within last 60 days)**

★ **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.

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

Income Verification Documents

Please identify which documents best reflect your financial means and bring them with you to your enrollment 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, you will need a signed statement by someone who has paid you for work in the past 30 days.
   - If self-employed and no tax return, provide bank statements.

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

3. If you are **UNEMPLOYED** and have $0 income:
   - "Letter of Support" completed by anyone who is supporting you financially
   - Zero Income Statement

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

5. If your spouse is **UNEMPLOYED**:
   - Zero Income Statement

6. If you're **SELF-EMPLOYED** and do not file a tax return, or are living off your saving, bank statements are required (dated within last 60 days)

7. If you or your spouse receive any of the following **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

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

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

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.

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

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 ☐ Medicaid Family Planning ☐ Other_____

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

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

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 does he/she 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: $_____

Workmans Comp: $_____

Child Support $_____

Other: $_____

TOTAL MONTHLY INCOME: $_____

Notes:

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 do not have private or dental insurance, Medicaid, Medicare nor have I enrolled in the Affordable Care Act.

My signature confirms the information I provided is true and correct to the best of my knowledge. I understand the information given will be verified.

Patient Signature_____ **Date**_____

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

Patient Agreement

1. **Moore Free & Charitable Clinic (MFCC)** is a not-for-profit organization that provides primary health and dental 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 and dental 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 – 1:00 pm.

5. **Patient Responsibility:** You are a vital part of the health and dental 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.

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

Patient Agreement cont'd

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 as a patient, I am not guaranteed nor am I 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, have a change in household income, or move outside of Moore County, 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: _____

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

Zero Income Statement

Please complete the Zero Income Statement below if you are no currently working and have no income or support. If you are married and your spouse is not working or receiving income, please have them complete the Zero Income Statement.

I,_____ Date of Birth: _____, certify that I am not currently working and have no income. I am able to receive mail at the following address: _____, which I have listed on the application.

Signature: _____ Date: _____

Signature: _____ Date: _____

Letter of Support

If you receive support by someone, please have them complete the Letter of Support on your behalf. (Example: lives with a friend or family member, receives money for food, housing, utilities.

I provide support for: _____ Date of Birth: _____ as indicated below.
(Print Patient's name)

Check only one of the boxes

- ▫ Lives with me at the address below and receives free room and board.
- ▫ Does not live with me, but I provide support as checked below.
  - o Food
  - o Housing
  - o Utilities
  - o Cash

_____ _____
(Signature) (Relationship with Patient)

_____ _____
(Print Your Name) (Print Street Address)

_____ _____
(Date) (Print City, State and Zip Code)

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

Moore Free & Charitable Clinic
Authorization for Use or Disclosure of Confidential Information

1. **General Consent.** I hereby authorize Moore Free & Charitable Clinic (MFCC) to use confidential information provided by me for the following purposes: determining eligibility for services, obtaining financial assistance for prescription medications and making referrals to social service organizations as needed.
2. **Authorization for Release of Personal Health Information.** I understand that under the Health Information Portability and Privacy Act (HIPPA), MFCC is not allowed to disclose my personal health information to any third party (except for the purposes of treatment, payment and operations) or family member without my written authorization. I hereby authorize MFCC to disclose my protected health information descried below to:
   Print Name _____
   Relationship to Patient _____ Phone No. _____

3. **Effective Period.** This authorization takes effect on the date of this form and ends on:
   - ▫ Specific date _____ or
   - ▫ when I am no longer a patient of MFCC.

4. **Extent of Authorization.** I authorize the release of any information in my health record (including records relating to metal health care, sexually transmitted diseases, and treatment of alcohol or drug abuse) OR
   - ▫ I authorize the release of any information in my health record with the exception of the following :
     Mental health notes
     Sexually transmitted diseases (including HIV/AIDS)
     Alcohol / drug abuse treatment
     Other (please specify): _____
5. **Right to Revoke.** I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
6. **Other.** I understand that my treatment, payment, enrollment, or eligibility for services will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient (or personal representative)

_____
Print name of patient (or personal representative and relationship to Patient)

Date: _____

Notes (office use only): _____