MADISON FREE CLINIC, INC.
125 N. Main Street
P.O. Box 914
Madison, Virginia
P: (540) 948-3667
F: (540) 948-2209
info@madisonfreeclinic.org

Dear MFC Patient,

Thank you for trusting us with your care. In order for us to give you the best care possible we request that you have open and clear communication with us. Please fill out all the information in this packet, then return to our office. In addition to this paperwork we will need a copy of your ID, proof of residency (electric bill, cell bill, etc) and proof of financial information, in the form of taxes, paystubs, or a letter of support.

Hours of operation (may vary) **Monday-Friday 9am-12pm.**
If you need us outside of these office hours, please leave a message on our ***office phone*** (540) 948-3667 or text the confidential ***office cell phone*** (540) 705-4095.
*Please be courteous in your communication and understand we will attempt to get back with you promptly.

Medications are managed at Madison Drug Co. you can request refills at (540) 948-4400 and they will contact us for approval. You will need to present a valid clinic Rx card at time of pickup. Patients have a $3 *per prescription* administrative fee, MFC will cover **up to $150 retail value of medications per month;** once that amount has been met, you will be responsible for the rest of the cost for the remainder of the month. Our staff and providers will work with you to maintain low cost medications.

Please know that we do our best to meet all of your needs, however our resources are limited. Please treat all of our partners at Madison Drug Co., Piedmont Regional Dental Clinic, EyeCare of Virginia- Dr. Press, & Hope Inspired Therapy- Sue Wood with respect; failure to do so could result in dismissal from our services.

MADISON FREE CLINIC, INC.
125 N. Main Street
P.O. Box 914
Madison, Virginia
P: (540) 948-3667
F: (540) 948-2209
info@madisonfreeclinic.org

Eligibility Requirements: Live in Madison County, meet 300% or less of the income guidelines (see chart) and be uninsured or underinsured. Please provide proof of income:

- 2 consecutive pay stubs
- Current taxes
- Statement from social security/disability for monthly income
- Bank statement
- If you are unemployed and have no income, please provide the attached letter of support from the person supporting you.

We will also need proof of residency:

- Drivers License/Photo I.D. Card
- Utility Bill with address & Name

2024 Federal Poverty Guideline Per Year								
House Size	**100%**	**130%**	**Medicaid 138%**	**150%**	**200%**	**250%**	**MCFC 300%**	**350%**
1	15,060.00	19,578.00	20,782.80	22,590.00	30,120.00	37,650.00	**45,180.00**	52,710.00
2	20,440.00	26,572.00	28,207.20	30,660.00	40,880.00	51,100.00	**61,320.00**	71,540.00
3	25,820.00	33,566.00	35,631.60	38,730.00	51,640.00	64,550.00	**77,460.00**	90,370.00
4	31,200.00	40,560.00	43,056.00	46,800.00	62,400.00	78,000.00	**93,600.00**	109,200.00
5	36,580.00	47,554.00	50,480.40	54,870.00	73,160.00	91,450.00	**109,740.00**	128,030.00
6	41,960.00	54,548.00	57,904.80	62,940.00	83,920.00	104,900.00	**125,880.00**	146,860.00
7	47,340.00	61,542.00	65,329.20	71,010.00	94,680.00	118,350.00	**142,020.00**	165,690.00
8	52,720.00	68,536.00	72,753.60	79,080.00	105,440.00	131,800.00	**158,160.00**	184,520.00

Updated 12/24

MADISON FREE CLINIC, INC.
125 N. Main Street
P.O. Box 914
Madison, Virginia
P: (540) 948-3667
F: (540) 948-2209
info@madisonfreeclinic.org

MFC Patient Application and Information Update Sheet

Date: _____

- New Application
- Renewal Application
- Patient Information Update (only fill in info that needs to be updated)

Name : _____
(First M. Initial Last)

Date of Birth: _____ Age:_____

Address:_____

_____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact:_____
(First M. Initial Last)

Relationship: _____ Phone Number: _____

General Information (circle the best answer):

MADISON FREE CLINIC, INC.
125 N. Main Street
P.O. Box 914
Madison, Virginia
P: (540) 948-3667
F: (540) 948-2209
info@madisonfreeclinic.org

Gender: Male/Female/Other, please identify _____

Marital Status: Single/Married/Divorced/Widowed/Other

Ethnicity: Non-Hispanic/Hispanic-Mexican/Puerto Rican/Cuban/Other

Race: Caucasian/African American/Asian/Native American/Other

Health Insurance: Uninsured/Medicaid/Medicare-needs vision/dental/prescription

Employment: Full-Time/Part-Time/Unemployed/Self-Employed

Please elaborate any 'Other' listed above: _____

Financial Questions:

Household size:_____
Names and Ages:

- _____
- _____
- _____
- _____

Patient's Monthly Income:_____ Spouse's Income:_____

MADISON FREE CLINIC, INC.
125 N. Main Street
P.O. Box 914
Madison, Virginia
P: (540) 948-3667
F: (540) 948-2209
info@madisonfreeclinic.org

What comprises your income? (circle all that apply):
Employment/Social Security/Disability/Unemployment/Other_____

What comprises your spouse's income? (circle all that apply):
Employment/Social Security/Disability/Unemployment/Other_____

Did you file taxes this year? Yes/No
Do you have UVA Financial assistance? Yes/No

Madison Free Clinic Patient Agreement

I, _____, agree to keep my Madison Free Clinic status up to date. I understand I could incur medical/dental/vision bills from the Providers the Free Clinic is partnered with if my status is expired. I understand I need to update my financial information once every 6 months, to stay active with the Clinic. I agree to update the Clinic if anything changes with my finances, medical insurance, phone number or residency.

Printed Name: _____

Signature: _____

Date: _____

Letter of support

Date: _____

MADISON FREE CLINIC, INC.
125 N. Main Street
P.O. Box 914
Madison, Virginia
P: (540) 948-3667
F: (540) 948-2209
info@madisonfreeclinic.org

To Whom It May Concern:

I, _____ certify that
(your name)

_____ lives in my home at
(patient name)

_____
(address)
and that I support him/her, with food, clothing, shelter and finances. I also certify that _____ is not employed at this time.

Printed Name: _____

Signature: _____

RELEASE OF RECORDS

MADISON FREE CLINIC, INC.
125 N. Main Street
P.O. Box 914
Madison, Virginia
P: (540) 948-3667
F: (540) 948-2209
info@madisonfreeclinic.org

I, _____, hereby authorize
(Patient Name)

_____
(Medical Office/Provider)

to release my medical records, including imaging, lab results and provider progress notes to Madison Free Clinic.

Patient Signature _____

Today's date _____ Patient's date of birth _____