Virginia B. Andes Volunteer Community Clinic

A Commitment to Caring

DOCUMENTATION NEEDED FOR SCREENING

To qualify as a patient at the Virginia B. Andes Volunteer Community Clinic you must be a Charlotte County resident, be over 18 years old, have no public or private health insurance, and be less than or equal to 200% of the Federal Poverty Guidelines.

The following information must be brought to your screening appointment in order to receive services:

1. **Photo identification**

2. **Proof of current Charlotte County address – 1 document of proof**
   - Examples of documentation - Photo ID, utility bill, lease/rental agreement, current pay stub with address, vehicle registration
   - If homeless, we need a letter from Homeless Coalition, Jesus Loves You Ministry, or other benefit agency and if not registered thru "coordinated entry", we will still see you but you will need to provide a letter of certification of homelessness from one of these agencies within 30 days

3. **Proof of income – Needed for all family unit members (i.e. patient, spouse/significant other/child)**
   - 1 month of current pay stubs (if applicable)
   - Current Bank Statements – all checking & savings (if applicable)
   - Current Unemployment letter – stating amount to be received (if applicable)
   - Current Social Security award letter – stating amount to be received (if applicable)

4. **Copy of Medical Records** (if needed)

Once packet is complete, please call the clinic at (941) 766-9570 to make a screening appointment.

Volunteer Health Care Provider Program

2021 Federal Poverty Guidelines

Family Size	Monthly 200%
1	$2,147
2	$2,903
3	$3,660
4	$4,417
5	$5,173
6	$5,930
7	$6,687
8	$7,443
9	$8,200
10	$8,957
For each additional person over the family size of 10, add	$757

SOURCE: Federal Register: January 19, 2021
New Levels went into effect as of January 19, 2021

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Patient Medical History

Last Name: First Name:	☐ Male ☐ Female	D.O.B
☐ Home Phone #	☐ Cell Phone Number#	Check Preferred Contact #
Address	Today's Date	Social Security #

MEDICAL INFORMATION

State primary reason for todays visit:_____

List previous outside doctors or ER visits:_____

Do you need new prescriptions for medications you will be out of in the next 30 days? ☐ Yes ☐ No

Health History	Health History	Health History
☐ Alcohol Intake –Light/Moderate/Heavy ☐ Tobacco Use – Light/Moderate/Heavy ☐ AIDS ☐ Allergies ☐ Alzheimer's ☐ Anemia ☐ Angina ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation ☐ Back Pain ☐ Behavioral Health Condition ☐ Bladder Disorder ☐ Bleeding Disorder ☐ Blood Clot(s) ☐ Bowel Disorder ☐ Breast Feeding ☐ Bursitis ☐ Cancer ☐ Cataracts ☐ Cholesterol, High ☐ COPD / Emphysema ☐ Dental Date of last visit ___/___/___ ☐ Depression ☐ Diabetes Insulin Dependent	☐ Diabetes Non-Insulin Dependent ☐ Emphysema ☐ Epilepsy ☐ Glaucoma ☐ Gout ☐ Heart Condition ☐ Hepatitis A ☐ B ☐ C ☐ ☐ Hypertension ☐ Hypo-Thyroid ☐ Hyper-Thyroid ☐ Kidney Disease ☐ Liver Disorder ☐ Lung Disease ☐ Macular Degeneration ☐ Migraine ☐ Neck Pain ☐ Osteoporosis ☐ Pacemaker ☐ Parkinson's Disease ☐ Peripheral Neuropathy ☐ Pregnancy ☐ Prostate Condition ☐ Sleeping disturbance ☐ Stroke ☐ Tendonitis ☐ Ulcers	Other:_____ Other:_____ Other:_____ Other:_____ **Medication/ Food Allergy** ☐ Aspirin ☐ Cephalosporins ☐ Codeine ☐ Eggs ☐ Erythromycin ☐ Food Additives/ Dyes ☐ NSAID's (ibuprofen, Naprosyn) ☐ Peanuts ☐ Penicillin ☐ Sulfa Drugs ☐ Tetracyclines ☐ Other_____ ☐ Other_____ ☐ Other_____ ☐ Other_____

HEALTH AND WELLNESS PROGRAMS

Would you like to participate in the following programs: Asthma / COPD Management ☐ Diabetes Education ☐
Exercise and Nutrition ☐ Medication Management ☐ Tobacco Cessation ☐

CURRENT MEDICATION PROFILE

List all prescription medications, OTC's and vitamins					
Medication	Dosage	Directions	Medication	Dosage	Directions
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

DEMOGRAPHICS

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

Ethnicity: White/Caucasian ☐ Black/African American ☐ Hispanic ☐
Native American ☐ Asian/Pacific ☐ Other:_____

Level of Education: High School ☐ Some College ☐ College Degree: ☐ Technical Degree ☐

Exercise:
Never ☐ 1-2 times a week ☐ 3-4 times a week ☐ Almost every day ☐

What type of exercise:_____

Family History:
Father: Alive ☐ Deceased ☐ Age ☐ Cause of Death_____

Mother: Alive ☐ Deceased ☐ Age ☐ Cause of Death_____

Siblings: Alive ☐ Deceased ☐ Age ☐ Cause of Death_____

Please check if the following conditions run in your family:

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Stroke ☐ Cystic Fibrosis
☐ Diabetes ☐ Asthma ☐ Rheumatoid Arthritis ☐ Cycle Cell Anemia ☐ Cancer

Height: _____ Weight: _____

Employer:_____ Occupation:_____

How were you referred to the VBA:_____

Notice of Limited Resources

Dear Patient,

Given that the Virginia B. Andes Volunteer Community Clinic is working with a finite allotted number of resources that may change from time to time there will be occasions when no resources will be available to you and we will be unable to provide the services you need. At that point we will have to deny services and will work with you to determine other possible options for your care.

Listed below are the items that we must have on file to provide you with service. Failure to provide these documents may delay your receipt of medications. To qualify for services income must be at or below 200% of the Federal Poverty Level

- Personal Identification and residency verification
- Proof or attestation of income such as a recent tax return, social security benefit award letter, 1 month of pay stubs, letter of support, or letter from homeless coalition.
- For pharmacy services a prescription for a formulary medication or a 90 day prescription for medications available thru manufacturer assistance programs
- Please note that determination of eligibility is required annually.

☐ *Presently I have no private, public, or government funded health insurance such as Medicare, Medicaid, or Veterans Benefits.*

☐ *All of the information that I have provided to the Virginia B. Andes Volunteer Community Pharmacy is correct to the best of my knowledge*

☐ *I understand that any changes in the information initially provided including my financial status or insurance status will be reported to the Clinic and Pharmacy immediately.*

☐ *I give my consent to release the minimum necessary health information to Pharmaceutical Companies for auditing purposes and help with obtaining my medications*

☐ *I understand that willful misrepresentation of any information provided will result in refusal of assistance now and in the future*

Signature of Patient: _____ Date:____/____/____

Signature of Screener: _____ Date: ____/____/____

Verification of Medicaid and Medicare Eligibility

I understand that in order to be eligible for services through the Virginia B. Andes Volunteer Community Clinic/Pharmacy, I must not have health insurance, including Medicaid or Medicare. My signature certifies that to the best of my knowledge, I do not have any public or private health insurance. Furthermore, I authorize a representative of the Virginia B. Andes Volunteer Community Clinic/Pharmacy to verify my Medicaid and Medicare status either by calling the Florida Department of Children and Families ACCESS Florida Hotline (866-762-2237) in my presence or checking on line with the Social Security Administration for Medicare coverage.

Patient Name: _____ Todays Date: ____/____/____

Patient Signature: _____

Social Security Number: _____ Date of Birth: ____/____/____

Medicaid Health Insurance Coverage ❑ Yes ❑ No

Screener Signature: _____ Date: _____/_____/_____

Medicare Health Insurance Coverage ❑ Yes ❑ No

Screener Signature: _____ Date: _____/_____/_____

1. Call ACCESS Hotline using speaker-phone at **1-866-762-2237**
2. Enter the Social Security Number
3. Enter the date of birth in mm/dd/yyyy format
   If no information is found the individual has not applied for benefits and you may end the call
4. Press 1 for case information.
5. Select the option to hear about benefits
   A. If applicable Medicaid or Share of Cost status is given second
   B. If benefits are available it will either state “Medicaid is Open” or the “Medically Needy” for the month is ___

Notice of Privacy Practice

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice describes how medical information about you may be used and disclosed and how you can get access to this medical information. Please review it carefully.

WE ARE REQUIRED BY LAW TO:

- Make sure that the medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to your medical information.
- Follow the terms of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

- For Treatment – We may disclose medical information about you to doctors, nurses and other health professionals who are involved in your medical care.
- For Health Care Operations – We may use this information to provide the best health care based on your medical condition. Information may have to be discussed with other charitable organizations, government organizations, businesses and pharmaceutical manufacturers that participate in assistance programs for auditing purposes only, or individuals from whom you or we may seek to provide assistance or additional help for you.
- Safety – When necessary to prevent a serious threat to the patient's health and safety or the health and safety of the public or another person
- Law Enforcement – We may release your information if asked to do so by a law enforcement officer. Examples would include a subpoena warrant summons, fugitive material witness, missing person, victim of a crime, criminal misconduct, an emergency situation involving a crime, or about a death.
- All other disclosures require a patient's written authorization which may be revoked at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

- Right to inspect and copy – you may request this at any time – a charge may be assessed for copying
- Right to amend – you may have us update and change incorrect information.
- Right to Request Restrictions – for example, you may request that we do not give out particular parts of your medical records to family members.
- Right to Confidential Communication – for example, you may request that we only contact you at home or by mail.

COMPLAINTS:

- All complaints about privacy violations or any other matter should be made to the Clinic Manager. You will not be penalized for making any complaints. You have the right to complain to the U.S. Department of Health and Human Services about any violations of your privacy at (404)562-7886.

WE RESERVE THE RIGHT TO UPDATE AND CHANGE THIS NOTICE AND POST A CORRECTED VERSION AT ALL TIMES

Patient Signature: _____ Date_____/_____/_____

Name and relation of other individual(s) we may disclose information to:_____

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PATIENT STATEMENT OF UNDERSTANDING

I understand that my eligibility dates for services are from _____ through _____. It will be my responsibility to show my eligibility card on each visit and to update my eligibility card through rescreening prior to the expiration date on the card. You will not be able to receive services either through the clinic or pharmacy without a current eligibility card.

I understand that the VBA staff and volunteers are committed to treating patients with politeness and respect and that you as a patient are expected to provide the same courtesy in return.

I understand the VBA building and grounds are a non-smoking campus.

I understand that if I miss either three appointments or scheduled prescription pick-ups without notification in advance, the VBA reserves the right to discharge me as a patient.

I understand that if I arrive late for an appointment, I may be rescheduled for a later time or another day.

I understand that prescription refills are to be called in 2 business days in advance.

I understand that the pharmacy has a formulary which may be viewed on our website (www.volunteercare.org) and some expensive medications will be required to be obtained thru a manufacturer assistance program which may take up to 2 weeks.

I understand that I play a role in my health care:

- It is my responsibility to follow through on testing and treatments offered by medical personnel at the Clinic
- As many diseases can be treated by lifestyle modifications alone I agree to disease prevention and management counseling and programs that the Clinic makes available so that a may be empowered to actively manage my healthcare
- I agree to take prescribed medications as directed and comply with refilling maintenance medications unless discussing concerns with either the prescribing provider or the pharmacist.
- Failure to comply with my treatment plan will make me ineligible for continued care at the Clinic

I understand that it is not always possible for the VBA to have a translator available. If I do not speak English, I will bring someone with me to my appointment to translate for me

Patient Signature:_____ Date:___/___/___

LETTER OF SUPPORT

Please help us determine the eligibility of the person listed below for assistance. Give specific answers to the following questions about the assistance or money you have loaned or given directly to this person. **We need specific dollar amounts to determine eligibility.** This form should be completed by the person providing help and/or sharing expenses with the client.

Name of Patient: _____

Patient's address: _____

Contact Phone #:_____

Name of person providing help (Person completing this form): _____

Relationship: _____

Phone # of person providing help (Person completing this form): _____

Please provide any assistance and/or how much money you have given this person(s) in the last 4 weeks. If no cash provided, please list **$0.00** for the amount given.

CASH/$ AMOUNT _____ ROOM & BOARD/$ VALUE _____

OTHER/$ VALUE _____

Is this person working or have any other sources of income? Yes _____ No _____
If yes, where are they employed and/or what other type of income

_____ _____

Signature of person providing help Date

Homeless ____Yes ____No (if yes please provide support letter from facility – i.e. Homeless Coalition, Jesus Loves You)