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:

A. Photo identification
(Note: *Does it have current address, if not also need Item B)*

B. Proof of current Charlotte County address – 1 document of proof
(Note: Only needed if photo ID does NOT have current address)

* 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

C. Provide Proof of Income

> All applicable items listed below are needed for ALL family unit members
(Note: Definition of a Family Unit: 1) you/the patient 2) if you live with a spouse or significant other, include them 3) include children under 18 4) include children ages 18-21 who are in school)

1) Current "Social Security Statement" (displays your earnings record history free of charge)
2) Previous year ***Complete*** Income Tax Return
3) 1 month of current pay stubs
4) Current Bank Statements (all checking & savings)
5) Current Unemployment letter stating amount to be received
6) Current Social Security Benefit Verification/Proof of Award Letter (retirement, disability, dependents, and survivors) award letter stating amount to be received

D. Eligibility Packet Completely Filled Out
(Note: If no income, "Explanation of How You Live With No Income" page in packet must be filled out)

Please don't hesitate to call with any questions as you are completing the paperwork.

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

VOLUNTEER HEALTH CARE PROVIDER PROGRAM
2023 FEDERAL POVERTY GUIDELINES – 200%

FAMILY SIZE	MONTHLY	YEARLY
1	$2,430	$29,160
2	$3,287	$39,440
3	$4,143	$49,720
4	$5,000	$60,000
5	$5,857	$70,280
6	$6,713	$80,560
7	$7,570	$90,840
8	$8,427	$101,120
9	$9,283	$111,400
10	$10,140	$121,680
For each additional person over the family size of 10, add	$857	10,280

SOURCE: Federal Register: January 24, 2023

Compiled by Chris Gainous
Volunteer Health Services
Florida Department of Health

1/24/2023

Virginia B. Andes Volunteer Community Clinic

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ELIGIBILITY SCREENING INFORMATION

NAME: _____ **DOB:** _____

VETERAN: ___ Yes ___No Disabled: ___ Yes ___No Over 65: ___ Yes ___ No

> Please list **EVERYONE** living in your home (including yourself)

NAME	DATE OF BIRTH	RELATIONSHIP

Do you live in a …….

____ Home ____ Apartment ____ Condo ____ Car ____ Tent ____ Homeless

____ Other (Explain _____)

Please estimate the CURRENT value of any ASSETS that you have:

_____ Cash On Hand _____Checking Account _____ Savings Account

_____ Investments (CDs, Bonds, IRAs, etc.)

_____House _____ Car _____Boat/Trailer _____ Camper/RV

Please give an ESTIMATE of your EXPENSES for the past 30 DAYS:

_____ Mortgage/Rent _____ Home Insurance _____ Utilities

_____ Food _____ Phone _____Credit Card Payments

_____ Car Payment _____ Car Insurance _____ Child Support

_____ Alimony _____Other (Explain _____)

I affirm that the information I am providing is true and correct.

_____ _____

SIGNATURE DATE

Virginia B. Andes Volunteer Community Clinic
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Patient Information

First Name:	Last Name:	Today's Date:
DOB:	Male ☐ Female ☐	Social Security #
Address:	City, ST:	Zip:
Home Phone #:	Cell Phone Number #:	Check Preferred Contact #: Home ☐ Cell ☐
Email Address:		
Communication Barriers: Vision ☐ Hearing ☐ Other_____	Language Preference: _____	Translator Needed: (Needed if English not language preference) Yes ☐ No ☐

DEMOGRAPHICS

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

Race: White/Caucasian ☐ Black/African American ☐
American Indian/Alaskan Native ☐ Asian/Pacific ☐ Other: _____

Ethnicity: Hispanic ☐ Non-Hispanic ☐

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

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

Mother: Age _____ Alive ☐ Deceased ☐ Cause of Death_____

Siblings: Age _____ Alive ☐ Deceased ☐ 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:_____

MEDICAL INFORMATION

Reason you need to see a medical provider: _____

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

Exercise: Never ☐ 1-2 times a week ☐ 3-4 times a week ☐ Almost every day ☐
What type of exercise: _____

CURRENT MEDICATION PROFILE

List all prescription medications, OTCs, and vitamins

Medication	Dosage	Directions	Medication	Dosage	Directions
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

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. ____ Patient Initials _____ Screener Intials

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.

Please initial to indicate understanding & acceptance……

_____ *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: ____/____/____

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

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

Verification of Medicaid and Medicare Eligibility

Patient Name: _____ Date of Birth: ____/____/____

Social Security Number: _____

I understand that 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 or checking online with the Social Security Administration for Medicare coverage.

Attestation Statements…….

I have Medicaid/Public Insurance	_____ Yes	_____ No
I have Medicare/Public Insurance	_____ Yes	_____ No
I have Disability Insurance/Public Insurance	_____ Yes	_____ No
I have Commercial Insurance/Private Insurance	_____ Yes	_____ No

Patient Signature: _____ Todays Date: ____/____/____

MEDICAID HEALTH INSURANCE COVERAGE VERIFICATION

Call ACCESS Hotline

Enter the Social Security Number

Enter the date of birth in mm/dd/yyyy format

- ❑ Yes – Has Medicaid
- ❑ No – Does not have Medicaid

Screener Signature: _____ Date: _____/_____/_____

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

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

NAME:_____

RELATIONSHIP:_____ CONTACT PHONE #: _____

NAME:_____

RELATIONSHIP:_____ CONTACT PHONE #: _____

****

PATIENT SIGNATURE:_____ DATE:_____/_____/_____

****

Virginia B. Andes Volunteer Community Clinic

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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:

(Note: Please initial below to indicate understanding of role)

_____ It is my responsibility to follow through on testing and treatments offered by medical personnel at the Clinic

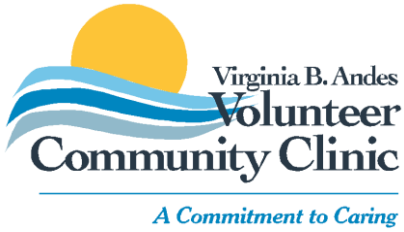
_____ As many diseases can be treated by lifestyle modifications alone, I agree to disease prevention and management counseling and programs that the Clinic makes available so that I may be empowered to actively manage my healthcare

_____ 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 to Patient: _____

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

Please provide/describe 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 _____ I

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)

Virginia B. Andes Volunteer Community Clinic

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EXPLANATION OF HOW YOU LIVE WITH NO INCOME

Patient Name: _____ DOB: _____

The following is an explanation my living situation which includes a description of where I live, how I pay for my residence, how I get food, how I get other essentials, etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I understand that in applying for eligibility, the information I provided above will be used to determine my eligibility. I further certify that the information provided above is true and correct, to the best of my knowledge.

I understand that any changes in income or household size are to be reported immediately.

_____ _____

Signature Date

SOCIAL SECURITY STATEMENT
(EARNINGS RECORD)

WAYS TO GET

LOCAL # > 877-405-0490
NATIONAL # > 800-772-1213

1) Go to local Social Security Office at 1600 Tamiami Trail – Suite 200, Port Charlotte, FL 33952 - Call local # to verify hours

2) Go online to www.socialsecurity.gov/myaccount and print statement
(Note: If having trouble with your account, call either the local or national number and they will help you fix it)

How to create a *my* Social Security account

Securing today and tomorrow

To create an account, you must:

- Be at least 18 years of age
- Have a Social Security number
- Have a valid U.S. mailing address
- Have an email address

1

Visit ***www.SocialSecurity.gov/myaccount*** and select **sign in to** or **create an account**.

2

Read and agree to the 'Terms of Service', **tell us** who you are, and **verify your identity**.

3

Create your **account detail**, select **how to receive** your security code, and **enter** your security code.

4

Now that you have **successfully** created your *my* Social Security **account**, choose **email or text** under 'Message Center Preferences' to receive courtesy notifications.

Create Your Account Today!

SocialSecurity.gov

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