Virginia B. Andes Volunteer Community Clinic
A Commitment to Caring

Patient Information – History & Physical (H&P)

PAGE 1 of 3 – Please complete ALL fields

Today's Date:	First Name:	Last Name:
DOB:	Social Security #:	County:
Address:	City, ST:	Zip:
Home Phone #:	Cell Phone Number #:	Check Preferred Contact #: ☐ Home ☐ Cell
Email Address:		Interested in Telehealth Services: ☐ Yes ☐ No
Communication Barriers: ☐ Vision ☐ Hearing ☐ Reading ☐ Writing ☐ Other_____	Language Preference: _____	Translator Required: ☐ Yes ☐ No

DEMOGRAPHICS

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

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

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other: _____ ☐ Declined

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

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:_____

****

FOR ADMINISTRATION USE ONLY

Collected At: ☐ ***Clinic*** ☐ ***Mobile Clinic*** ***Living Status:*** ☐ ***Housed*** ☐ ***Unhoused***

Eligibility Packet: ☐ ***Complete*** ☐ ***Incomplete*** ***Eligibility Expires:*** _____

Virginia B. Andes Volunteer Community Clinic
A Commitment to Caring

Patient Information – History & Physical (H&P)

PAGE 2 of 3 – Please complete ALL fields

PATIENT NAME: _____ DOB: _____

Reason you need to see a medical provider: _____

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

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 and Over the Counter medications including vitamins

Medication	Dosage	Directions	Needed w/in 30 Days	Medication	Dosage	Directions	Needed w/in 30 Days
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

Virginia B. Andes Volunteer Community Clinic

A Commitment to Caring

Patient Information – History & Physical (H&P)

Page 3 of 3 – Please complete ALL fields

PATIENT NAME: _____

LIST PREVIOUS OUTSIDE DOCTORS/HOSPITAL STAYS/ER VISITS IN LAST 2 YEARS:

DOCTOR/HOSPITAL FULL NAME	WHY SEEN	CITY, STATE	PHONE #	FAX #	DATE LAST SEEN	WILL YOU CONTINUE TO SEE (Y/N)	DO YOU SELF-PAY (Y/N)	MEDICAL RECORDS REQ (Y/N)

COMMENTS:

_____

_____

_____

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

CONFIDENTIAL

PATIENT NAME: _____ **DOB:** _____

INFORMATION MAY BE DISCLOSED BY:

Person/Facility:_____ Phone #: _____

Address:_____ Fax #: _____

INFORMATION MAY BE DISCLOSED TO:

> **EMAIL Address: vbamedicalrecords@volunteercare.org**

Person/Facility: Virginia B. Andes Volunteer Community Clinic Phone #: (941) 766-9570

Address: 21297 Olean Blvd., Suite B, Port Charlotte, FL 33952 Fax #: (941) 979-5058

I specifically authorize the release of information relating to:

☐ Last 5 Years ☐ Specific Dates: _____

⊗ Medication List ⊗ Labs/Medical Imaging ⊗ Discharge Summary

⊗ General Medical Record(s), including STD and TB Results ⊗ Physician Progress Notes

⊗ History and Physical Results ⊗ Consultations

☐ Other (Specify): _____

I specifically authorize the release of information relating to: (initial selection)

⊗ HIV test results for non-treatment purposes ⊗ Substance Abuse Service Provider Client Records

⊗ Psychiatric, Psychological or Psychotherapeutic notes

PURPOSE OF DISCLOSURE:

⊗ Continuity of Care ☐ Personal Use ☐ Other (Specify): _____

***EXPIRATION DATE: This** authorization will expire (insert date or event)_____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.*

***REDISCLOSURE:** I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.*

***CONDITIONING:** I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.*

***REVOCATION:** I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.*

_____ _____

Patient or Legally Authorized Representative Signature Date

If other than patient signing, state relationship: _____

_____ _____

Witness Signature Date

Patient Name: _____ **DOB:** _____

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

A Commitment to Caring

Patient Name: _____ **DOB:** _____

PATIENT STATEMENT OF UNDERSTANDING & ACCEPTANCE

> I understand that my eligibility dates for services are from _____ through _____.
> I understand it is 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. I understand I will not be able to receive services either through the clinic or pharmacy without a current eligibility card.
> I presently have no private insurance, public insurance, or government funded health insurance such as Medicare, Medicaid, or Veterans Benefits.
> All the information that I have provided to the Virginia B. Andes (VBA) Volunteer Community Clinic 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 VBA immediately.
> I give my consent to release the 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.
> 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 three appointments without notification in advance, 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 the VBA pharmacy needs 2 business days advance notice to process prescription refills.
> I understand that some expensive medications will be required to be obtained thru a manufacturer assistance program which may take up to 2 weeks.
> I understand that VBA's provider staff consists of volunteer resources and may change from time to time. There will be occasions when VBA may not have the resources to provide the services I need. If this happens, VBA will work with me to determine other possible options for my care.
> 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 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.
* I understand failure to comply with my treatment plan will make me ineligible for continued care at VBA.
> 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:___/___/___

Virginia B. Andes Volunteer Community Clinic

A Commitment to Caring

PATIENT STATEMENT OF UNDERSTANDING & ACCEPTANCE (PATIENT COPY)

> I understand that my eligibility dates for services are from _____ through _____.
> I understand it is 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. I understand I will not be able to receive services either through the clinic or pharmacy without a current eligibility card.
> I presently have no private insurance, public insurance, or government funded health insurance such as Medicare, Medicaid, or Veterans Benefits.
> All the information that I have provided to the Virginia B. Andes (VBA) Volunteer Community Clinic is correct to the best of my knowledge.
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* 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.
* I understand failure to comply with my treatment plan will make me ineligible for continued care at VBA.
> 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:___/___/___

PATIENT DOCUMENTATION ATTESTATION CHECKLIST

PATIENT NAME: _____ **DOB:**_____

ELIGIBILITY STATUS: **ELIGIBILITY CARD GIVEN:** _____**YES** _____**NO**
_____**COMPLETE** _____**PENDING (Missing Documentation)** _____**INELIGIBILE (WHY:**_____**)**

IF MISSING DOCUMENTATION NOT RECEIVED, PATIENT WILL BE INACTIVATED ON_____

I attest that the status of the required documents is accurate and correct and that I understand all missing documentation needs to be provided within 30 days or my eligibility will be inactivated

_____ _____
PATIENT SIGNATURE ***Date***

DOCUMENT	PATIENT	SPOUSE/PARTNER NAME:_____
1032E	_X__COMPLETE ___INCOMPLETE ***Signed by Patient & Screener***	***(NOTE: CHECK LIST FOR CHILDREN IS ON REVERSE SIDE)***
INTAKE PACKET	_X__COMPLETE ___INCOMPLETE	
Photo ID	_X__REC'D ___MISSING NAME OF PROVIDED DOCUMENT: _____	
Proof of Current Charlotte County address	___REC'D _X__MISSING NAME OF PROVIDED DOCUMENT: _____	
SS Earnings Record	___REC'D __X_MISSING ___WAIVER	___REC'D _X_MISSING _WAIVER
Tax Return (1040)	___REC'D _X__MISSING ___ WAIVER	___REC'D _X_MISSING _WAIVER
Copy of Current Month Pay Stubs	___REC'D __X_MISSING ___SELF EMPLOYED STATEMENT ___NOT EMPLOYED STATEMENT	___REC'D __X_MISSING ___SELF EMPLOYED STATEMENT ___NOT EMPLOYED STATEMENT
All Current Month Bank Statements	___REC'D _X__MISSING ___N/A	___REC'D __X_MISSING ___NO FINANCIAL ACOUNTS
Unemployment Award Letter	___REC'D _X__MISSING ___N/A	___REC'D _X__MISSING ___N/A
Benefits Award Letter (SS, SSI, SSDI, VA, etc)	___REC'D _X__MISSING ___N/A	___REC'D _X__MISSING ___N/A

PROVIDE ALL MISSING DOCUMENTATION TO: JACI ANDERSON, OFFICE MANAGER
PHONE: 941-766-9570 x142 ***EMAIL: janderson@volunteercare.org***

PATIENT DOCUMENTATION ATTESTATION CHECKLIST

PATIENT NAME: _____ **DOB:**_____

DOCUMENT	CHILDREN 0-17	CHILDREN 18-21
1032E		
INTAKE PACKET		
Photo ID		
Proof of Current Charlotte County address		
SS Earnings Record	___REC'D ___MISSING __WAIVER	___REC'D ___MISSING ___WAIVER
Tax Return (1040)	___REC'D ___MISSING __WAIVER	___REC'D ___MISSING ___WAIVER
Copy of Current Month Pay Stubs	___REC'D __X_MISSING ___SELF EMPLOYED STATEMENT ___NOT EMPLOYED STATEMENT	___REC'D __X_MISSING ___SELF EMPLOYED STATEMENT ___NOT EMPLOYED STATEMENT
All Current Month Bank Statements	___REC'D ___MISSING ___NO FINANCIAL ACOUNTS	___REC'D ___MISSING ___NO FINANCIAL ACOUNTS
Unemployment Award Letter	___REC'D ___MISSING ___N/A	___REC'D ___MISSING ___N/A
Benefits Award Letter (SS, SSI, SSDI, VA, etc)	___REC'D ___MISSING ___N/A	___REC'D ___MISSING ___N/A

PROVIDE ALL MISSING DOCUMENTATION TO: JACI ANDERSON, OFFICE MANAGER
PHONE: 941-766-9570 x142 EMAIL: janderson@volunteercare.org

SUMMARY OF DOCUMENTATION NEEDED FOR ELIGIBILITY APPROVAL

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 300% of the Federal Poverty Guidelines**.

2025 FEDERAL POVERTY GUIDELINES – 300%

(NOTE: Waiting for confirmation)

FAMILY SIZE	MONTHLY	YEARLY
1	$3,912.50	$46,950
2	$5287.50	$63,450

BELOW ITEMS ARE REQUIRED FOR PATIENT ONLY:

> **ATTESTATION - Photo Identification – i.e. Driver License, Passport, Government ID Card – Page 3**
> **(Note: *Does it have current address, if not also need Proof of Charlotte County Address)***

> **ATTESTATION - Proof of Charlotte County Address – 1 document of proof – Page 3**
> ***(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

BELOW ITEMS ARE REQUIRED FOR THE PATIENT, THE SPOUSE/SIGNIFIANT OTHER/PARTNER, ALL CHLIDREN UNDER 18, AND ALL CHILDREN 18-21 WHO ARE IN SCHOOL:

> **ATTESTATION - SS Earning Record and/or Tax Return Attestation – Page 4**
> *Example - Current Social Security Statement (Earnings Record) Example – Page 5*
> *Example - Previous year Complete Income Tax Return (Form 1040) Example – Page 6*
> **ATTESTATION - Most recent 30 days/1 month of current pay stubs/cash earnings statement – Page 7**
> **ATTESTATION - Current Bank Statements (all checking & savings) - Page 8**
> **ATTESTATION - Current Unemployment letter stating amount to be received - Page 9**
> **ATTESTATION - Current Proof of Award Letter stating amount to be received (i.e.retirement, disability, dependents, survivors, veteran benefits - Page 10**

PHOTO ID ATTESTATION

_____ I provided a copy of my photo ID when I submitted Part 1 of the Eligibililty Packet at my first visit.

_____ I am providing a copy of my photo ID with this packet - Part 2.

PROOF OF ADDRESS ATTESTATION

_____ I have attached the following document to prove my Charlotte County residency….(please select one of the following)……..

_____ Photo ID
_____ Billing Statement (i.e. electric bill)
_____ Lease agreement
_____ Pay stub w/address
_____ Vehicle Registration
_____ Letter from an agency (i.e. Charlotte Cares, Gulf Coast Partnership)
_____ Letter from person who is providing you housing
_____ Other > _____

_____ I attest that I have no way to obtain written proof of my address and state that I stay at the following address or intersection……..

_____

_____

_____

_____

_____ _____

PATIENT SIGNATURE ***Date***

Virginia B. Andes Volunteer Community Clinic
A Commitment to Caring

SS EARNINGS RECORD/1040 ATTESTATION

PATIENT NAME: _____ DOB: _____

> Social Security Earnings Record

Note: Mark applicable box with an "X"

OPTIONS	PATIENT	SPOUSE/PARTNER	CHILD (16-21)
SS EARNINGS RECORD IS ATTACHED			
DO NOT HAVE A SS #			
WILL PROVIDE LATER			
WILL NOT PROVIDE			

> Complete 1040 Tax Return

Note: Mark applicable box with an "X"

OPTIONS	PATIENT	SPOUSE/PARTNER	CHILD (16-21)
1040 IS ATTACHED			
DID NOT FILE			
WILL PROVIDE LATER			
WILL NOT PROVIDE			

By signing this, I attest that I understand I may not be able to get medication from the Patient Assistance Program if I chose not to provide a copy of the Social Security Earnings Record and/or the 1040 Tax Return. If at some point medication is needed from the Patient Assistance Program, the applicable documentation will need to be provided.

_____ _____

Patient Signature Date

EXAMPLE - Current Social Security Statement Earnings Record

Note: ***Required For The Patient, The Spouse/Signifiant Other/Partner, All Chlidren Under 18, And All Children 18-21 Who Are In School***

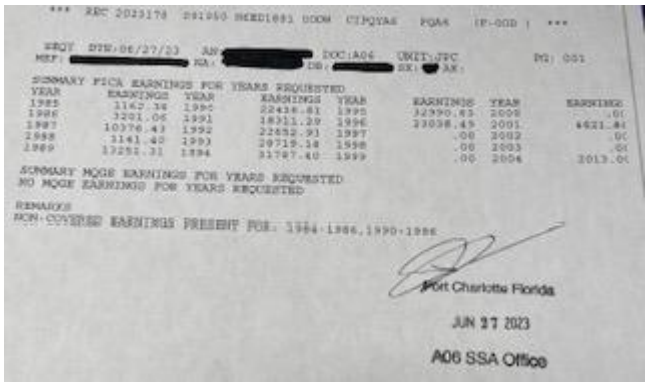
WAYS TO OBTAIN

1) Go to local Social Security Office:
   > Address: 1600 Tamiami Trail – Suite 200, Port Charlotte, FL 33952
   > Phone #s: Local # > 877-405-0490 or National # > 800-772-1213

   OR

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)

EXAMPLES OF SOCIAL SECURITY EARNINGS RECORDS



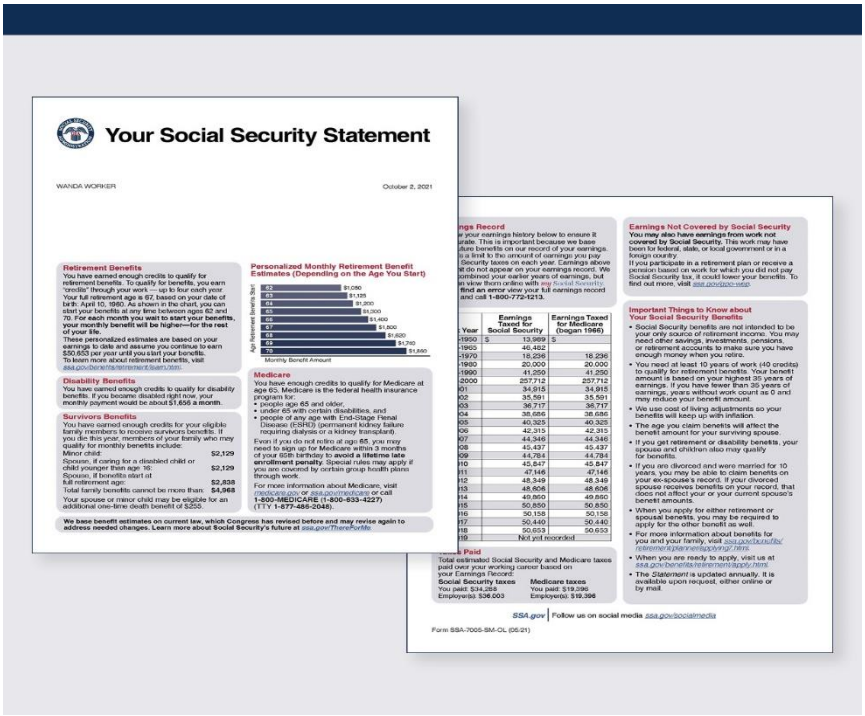
SUMMARY FICA EARNINGS FOR YEARS REQUESTED

YEAR	EARNINGS	YEAR	EARNINGS	YEAR	EARNINGS	YEAR	EARNINGS
1985	1162.38	1990	22436.61	1995	32990.63	2000	.00
1986	3201.06	1991	18311.20	1996	33038.49	2001	4621.84
1987	10376.43	1992	22852.93	1997	.00	2002	.00
1988	3141.40	1993	20719.18	1998	.00	2003	.00
1989	17251.31	1994	31787.40	1999	.00	2004	2013.00

SUMMARY MQGE EARNINGS FOR YEARS REQUESTED
NO MQGE EARNINGS FOR YEARS REQUESTED

REMARKS
NON-COVERED EARNINGS PRESENT FOR: 1984-1986,1990-1996

Port Charlotte Florida
JUN 27 2023
A06 SSA Office



Your Social Security Statement

WANDA WORKER

October 2, 2021

Retirement Benefits
You have earned enough credits to qualify for retirement benefits. To qualify for benefits, you earn "credits" through your work — up to four each year. Your full retirement age is 67, based on your date of birth: April 10, 1960. As shown in the chart, you can start your benefits at any time between ages 62 and 70. For each month you wait to start your benefits, your monthly benefit will be higher—for the rest of your life.
These personalized estimates are based on your earnings to date and assume you continue to earn $50,653 per year until you start your benefits.
To learn more about retirement benefits, visit ssa.gov/benefits/retirement/learn.html.

Personalized Monthly Retirement Benefit Estimates (Depending on the Age You Start)

Age Retirement Benefits Start	Monthly Benefit Amount
62	$1,090
63	$1,135
64	$1,200
65	$1,300
66	$1,400
67	$1,800
68	$1,920
69	$1,740
70	$1,860

Disability Benefits
You have earned enough credits to qualify for disability benefits. If you became disabled right now, your monthly payment would be about $1,656 a month.

Survivors Benefits
You have earned enough credits for your eligible family members to receive survivors benefits. If you die this year, members of your family who may qualify for monthly benefits include:

Minor child:	$2,129
Spouse, if caring for a disabled child or child younger than age 16:	$2,129
Spouse, if benefits start at full retirement age:	$2,838
Total family benefits cannot be more than:	$4,968

Your spouse or minor child may be eligible for an additional one-time death benefit of $255.

Medicare
You have enough credits to qualify for Medicare at age 65. Medicare is the federal health insurance program for:
- people age 65 and older,
- under 65 with certain disabilities, and
- people of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Even if you do not retire at age 65, you may need to sign up for Medicare within 3 months of your 65th birthday to avoid a lifetime late enrollment penalty. Special rules may apply if you are covered by certain group health plans through work.

For more information about Medicare, visit medicare.gov or ssa.gov/medicare or call 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048).

We base benefit estimates on current law, which Congress has revised before and may revise again to address needed changes. Learn more about Social Security's future at ssa.gov/TheresTomorrow.

ngs Record
e your earnings history below to ensure it urate. This is important because we base ture benefits on our record of your earnings. s a limit to the amount of earnings you pay Security taxes on each year. Earnings above t do not appear on your earnings record. We ombined your earlier years of earnings, but w them online with my Social Security. find an error view your full earnings record and call 1-800-772-1213.

Year	Earnings Taxed for Social Security	Earnings Taxed for Medicare (began 1966)
1950	$ 13,989	$
1965	46,462	
1970	18,236	18,236
1980	20,000	20,000
1990	41,250	41,250
2000	257,712	257,712
01	34,915	34,915
02	35,591	35,591
03	36,717	36,717
04	38,686	38,686
05	40,325	40,325
06	42,315	42,315
07	44,346	44,346
08	43,437	43,437
09	44,784	44,784
10	45,847	45,847
11	47,148	47,148
12	48,349	48,349
13	48,606	48,606
14	49,860	49,860
15	50,850	50,850
16	50,158	50,158
17	50,440	50,440
18	50,653	50,653
19	Not yet recorded	

s Paid
Total estimated Social Security and Medicare taxes paid over your working career based on your Earnings Record:

Social Security taxes	Medicare taxes
You paid: $34,268	You paid: $19,296
Employers: $36,003	Employers: $19,296

Earnings Not Covered by Social Security
You may also have earnings from work not covered by Social Security. This work may have been for federal, state, or local government or in a foreign country.
If you participate in a retirement plan or receive a pension based on work for which you did not pay Social Security tax, it could lower your benefits. To find out more, visit ssa.gov/ppo-wep.

Important Things to Know about Your Social Security Benefits
- Social Security benefits are not intended to be your only source of retirement income. You may need other savings, investments, pensions, or retirement accounts to make sure you have enough money when you retire.
- You need at least 10 years of work (40 credits) to qualify for retirement benefits. Your benefit amount is based on your highest 35 years of earnings. If you have fewer than 35 years of earnings, years without work count as 0 and may reduce your benefit amount.
- We use cost of living adjustments so your benefits will keep up with inflation.
- The age you claim benefits will affect the benefit amount for your surviving spouse.
- If you get retirement or disability benefits, your spouse and children also may qualify for benefits.
- If you are divorced and were married for 10 years, you may be able to claim benefits on your ex-spouse's record. If your divorced spouse receives benefits on your record, that does not affect your or your current spouse's benefit amounts.
- When you apply for either retirement or spouse benefits, you may be required to apply for the other benefit as well.
- For more information about benefits for you and your family, visit ssa.gov/pubs/ss/retirement/planningapplying2.htm.
- When you are ready to apply, visit us at ssa.gov/benefits/retirement/apply.html.
- The *Statement* is updated annually. It is available upon request, either online or by mail.

SSA.gov | Follow us on social media ssa.gov/socialmedia

Form SSA-7005-SM-OL (05-21)

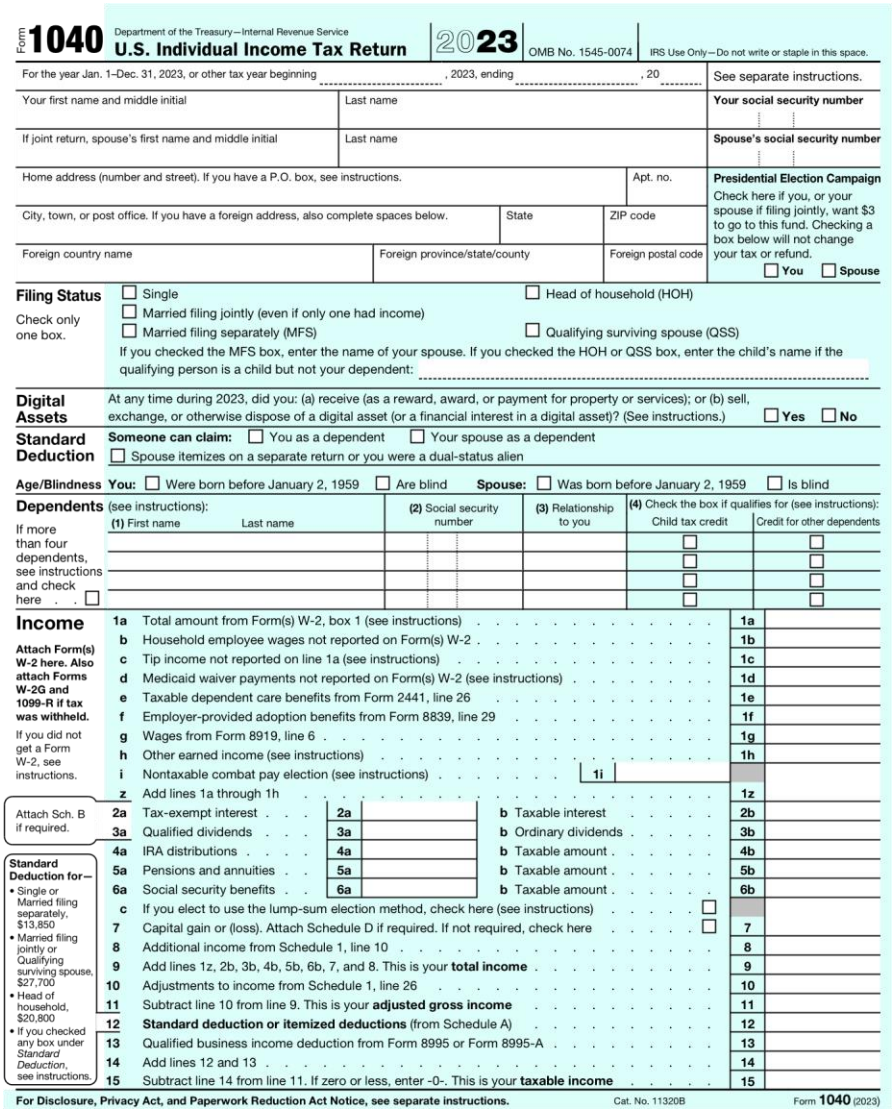
Virginia B. Andes Volunteer Community Clinic
A Commitment to Caring

EXAMPLE - PREVIOUS YEAR ***COMPLETE*** INCOME TAX RETURN (FORM 1040)

NOTE 1: NEED ALL PAGES

NOTE 2: *REQUIRED FOR THE PATIENT, THE SPOUSE/SIGNIFIANT OTHER/PARTNER, ALL CHILDREN UNDER 18, AND ALL CHILDREN 18-21 WHO ARE IN SCHOOL*

> Tax Return – sample of 1ST page only – need ALL pages



Form **1040** Department of the Treasury—Internal Revenue Service **U.S. Individual Income Tax Return** 2023 OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

For the year Jan. 1–Dec. 31, 2023, or other tax year beginning , 2023, ending , 20 — See separate instructions.

Your first name and middle initial | Last name | Your social security number

If joint return, spouse's first name and middle initial | Last name | Spouse's social security number

Home address (number and street). If you have a P.O. box, see instructions. | Apt. no. | Presidential Election Campaign

City, town, or post office. If you have a foreign address, also complete spaces below. | State | ZIP code

Foreign country name | Foreign province/state/county | Foreign postal code

Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. ☐ You ☐ Spouse

Filing Status Check only one box.
☐ Single ☐ Married filing jointly (even if only one had income) ☐ Married filing separately (MFS) ☐ Head of household (HOH) ☐ Qualifying surviving spouse (QSS)
If you checked the MFS box, enter the name of your spouse. If you checked the HOH or QSS box, enter the child's name if the qualifying person is a child but not your dependent:

Digital Assets At any time during 2023, did you: (a) receive (as a reward, award, or payment for property or services); or (b) sell, exchange, or otherwise dispose of a digital asset (or a financial interest in a digital asset)? (See instructions.) ☐ Yes ☐ No

Standard Deduction **Someone can claim:** ☐ You as a dependent ☐ Your spouse as a dependent
☐ Spouse itemizes on a separate return or you were a dual-status alien

Age/Blindness **You:** ☐ Were born before January 2, 1959 ☐ Are blind **Spouse:** ☐ Was born before January 2, 1959 ☐ Is blind

Dependents (see instructions): If more than four dependents, see instructions and check here ☐

(1) First name Last name	(2) Social security number	(3) Relationship to you	(4) Check the box if qualifies for (see instructions): Child tax credit	Credit for other dependents
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Income **Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.** If you did not get a Form W-2, see instructions.

1a	Total amount from Form(s) W-2, box 1 (see instructions)			1a
b	Household employee wages not reported on Form(s) W-2			1b
c	Tip income not reported on line 1a (see instructions)			1c
d	Medicaid waiver payments not reported on Form(s) W-2 (see instructions)			1d
e	Taxable dependent care benefits from Form 2441, line 26			1e
f	Employer-provided adoption benefits from Form 8839, line 29			1f
g	Wages from Form 8919, line 6			1g
h	Other earned income (see instructions)			1h
i	Nontaxable combat pay election (see instructions)	1i		
z	Add lines 1a through 1h			1z
2a	Tax-exempt interest 2a		b Taxable interest	2b
3a	Qualified dividends 3a		b Ordinary dividends	3b
4a	IRA distributions 4a		b Taxable amount	4b
5a	Pensions and annuities 5a		b Taxable amount	5b
6a	Social security benefits 6a		b Taxable amount	6b
c	If you elect to use the lump-sum election method, check here (see instructions) ☐			
7	Capital gain or (loss). Attach Schedule D if required. If not required, check here ☐			7
8	Additional income from Schedule 1, line 10			8
9	Add lines 1z, 2b, 3b, 4b, 5b, 6b, 7, and 8. This is your **total income**			9
10	Adjustments to income from Schedule 1, line 26			10
11	Subtract line 10 from line 9. This is your **adjusted gross income**			11
12	**Standard deduction or itemized deductions** (from Schedule A)			12
13	Qualified business income deduction from Form 8995 or Form 8995-A			13
14	Add lines 12 and 13			14
15	Subtract line 14 from line 11. If zero or less, enter -0-. This is your **taxable income**			15

Attach Sch. B if required.

Standard Deduction for—
- Single or Married filing separately, $13,850
- Married filing jointly or Qualifying surviving spouse, $27,700
- Head of household, $20,800
- If you checked any box under *Standard Deduction*, see instructions.

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 11320B Form **1040** (2023)

Virginia B. Andes Volunteer Community Clinic
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ATTESTATION - MOST RECENT 30 DAYS/1 MONTH OF CURRENT PAY STUBS/CASH EARNINGS STATEMENT

Sample of a "pay stub"

PAY STUB

Employee Information		Pay Stub Information	
Employee Name:	Ora W. D'Amato	Pay Period Start:	08/01/2023
Address:	4462 Selah Way	Pay Period End:	08/31/2023
	South Burlington, VT 05403	Issue Date:	09/03/2023
Employee ID:	100025482	SSN:	5024-XXXX
Department:	Research & Development	Check Number:	0000-1111-2222-3333

EARNINGS

Pay Description	YTD	Hours/Qty	Rate	Amount
Regular Work	$38,559.00	176	$24.00	$4,224.00
Overtime	$3,000.00	12	$40.00	$480.00
Bonus	$495.00	1	$250.00	$250.00
TOTAL EARNINGS	$42,054.00			$4,954.00

DEDUCTIONS

Description	Year to Date	Amount
Medicare 1.45%	$568.00	$71.83
Federal Income Taxes	$2,356.00	$256.00
Social Security	$1,380.00	$150.00
State Tax	$450.00	$50.00
Insurance	$360.00	$40.00
Loans	$5,580.00	$605.00
TOTAL DEDUCTIONS	$10,694.00	$1,172.83

____ I have attached 1 month of current pay stubs

____ I have zero income

____ I have completed the income statement below as I am self-employed

Being self-employed, I attest that I made _____ in the last 30 days.

_____ _____

PATIENT SIGNATURE ***Date***

Virginia B. Andes Volunteer Community Clinic

A Commitment to Caring

BANK (CHECKING/SAVING) STATEMENTS

SAMPLE BANK STATEMENT: Has Name, Address, Deposit & Withdrawal Summary, List of Transactions

1000 Walnut
Kansas City MO 64106-3686

Jane Customer
1234 Anywhere Dr.
Small Town, MO 12345-6789

Primary Account Number: **000009752**

Bank Statement

If you have any questions about your statement, please call us at 816-234-2265

Statement Date: **June 5, 2003**
Page Number: **1**

CONNECTIONS CHECKING Account # 000009752

Account Summary Account # 000009752

Beginning Balance on May 3, 2003	$7,126.11
Deposits & Other Credits	+3,615.08
ATM Withdrawals & Debits	-20.00
VISA Check Card Purchases & Debits	-0.00
Withdrawals & Other Debits	-0.00
Checks Paid	-200.00
Ending Balance on June 5, 2003	**$10,521.19**

Deposits & Other Credits Account # 000009752

Description		Date Credited	Amount
Deposit	Ref Nbr: 130012345	05-15	$3,615.08
Total Deposits & Other Credits			**$3,615.08**

ATM Withdrawals & Debits Account # 000009752

Description	Tran Date	Date Paid	Amount
ATM Withdrawal 1000 Walnut St M119 Kansas City MO 00005678	05-18	05-19	$20.00
Total ATM Withdrawals & Debits			**$20.00**

Checks Paid Account # 000009752

Date Paid	Check Number	Amount	Reference Number
05-12	1001	75.00	00012576589
05-18	1002	30.00	00036547854
05-24	1003	200.00	00094613547

_____ I have attached the most recent statement/s

_____ I do not have any bank accounts

_____ _____

PATIENT SIGNATURE ***Date***

Virginia B. Andes Volunteer Community Clinic
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SAMPLE OF CURRENT UNEMPLOYMENT LETTER STATING AMOUNT TO BE RECEIVED

Effective Date: **03/15/2020** Benefit Year End: **03/14/2021** Claim Status: **Active**

Monetary Information

Weekly Benefit Amount:	$0	Balance:	$0	Monetary Status:	Pending
Maximum Benefit Amount:	$0	Earnings Disregard	$58.00	File Date:	03/19/2020

Requested Benefit Payment Information

Last Week Signed:	3/22/2020 - 3/28/2020	Waiting Week:		Current Program Type:	Regular UC
Last Week Paid:		Service Language:	English		

IMPORTANT ITEMS THAT NEED YOUR IMMEDIATE ATTENTION - CLICK ON LINK TO VIEW ITEMS

Messages - Notice of events, status changes, and other available actions

- You may log back in to CONNECT on 04/13/2020 to request benefit payment for your next available week(s). Your deadline to request those weeks is 04/23/2020.
- Your application for unemployment benefits has been received and is being processed.

Unemployment Award Letter: _____ Attached _____ Do Not Receive

SAMPLE OF PROOF OF AWARD LETTER STATING AMOUNT TO BE RECEIVED
(I.E.RETIREMENT, DISABILITY, DEPENDENTS, SURVIVORS, VETERAN BENEFITS

Social Security Administration
Benefit Verification Letter

Date: August 16, 2022
BNC#: 123456789ABCDE
REF: A

JONATHAN DOE
1234 MAKEBELIEVE LANE
AKRON, OH 44312

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

Information About Current Social Security Benefits

Beginning December 2021, the full monthly Social Security benefit before any deductions is $2,908.00.

We deduct $170.10 for medical insurance premiums each month.

The regular monthly Social Security payment is $2,737.00.
(We must round down to the whole dollar.)

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the second Wednesday of each month.

Information About Past Social Security Benefits

From December 2020 to November 2021, the full monthly Social Security benefit before any deductions was $2,746.00.

We deducted $148.50 for medical insurance premiums each month.

The regular monthly Social Security payment was $2,597.00.
(We must round down to the whole dollar.)

Type of Social Security Benefit Information

You are entitled to monthly retirement benefits.

Medicare Information

You are entitled to hospital insurance under Medicare beginning October 2016.

Award Letter (i.e. SS, Pension, etc): _____ Attached _____ Do Not Receive

_____ _____

PATIENT SIGNATURE ***Date***