

Patient Information – History & Physical (H&P)

PAGE 1 of 4 – 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 #: <input type="checkbox"/> Home <input type="checkbox"/> Cell
Email Address:	Interested in Telehealth Services: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Communication Barriers: <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Reading <input type="checkbox"/> Writing <input type="checkbox"/> Other _____	Language Preference: _____	Translator Required: <input type="checkbox"/> Yes <input type="checkbox"/> No

DEMOGRAPHICS

<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married/Significant Other <input type="checkbox"/> Other _____	# of Children living at home: > Ages 0-17 _____ > Ages 18-21 AND are In school _____
Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian/Pacific <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined		
Level of Education: <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> College Degree: <input type="checkbox"/> Technical Degree <input type="checkbox"/> Other _____		
Family History: Father: Age _____ <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Cause of Death _____ Mother: Age _____ <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Cause of Death _____ Siblings: Age _____ <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Cause of Death _____ Please check if the following conditions run in your family: <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Stroke <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Cycle Cell Anemia <input type="checkbox"/> Cancer		
Height: _____		Weight: _____
Employer: _____		Occupation: _____
How were you referred to the VBA: _____		

***** FOR ADMINISTRATION USE ONLY

Patient Type: ☐ Clinic ☐ BUS ☐ Mixed Housing Status: ☐ Housed ☐ Unhoused

Employment Status: ☐ Employed ☐ Unemployed

Eligibility Packet: ☐ Complete ☐ Incomplete Eligibility Expires: _____

Insurance: ☐ NOT Checked ☐ Checked ☐ Has Insurance ☐ Does Not Have Insurance

FAMILY UNIT WORKSHEET – PAGE 2 of 4

- **NEEDED IF MORE THAN 1 IN THE FAMILY UNIT**
- **LIST SPOUSE/PARTNER AND ALL CHILDREN WHO ARE LIVING AT HOME**

PATIENT NAME: _____ **DOB:** _____

NAME	DOB	RELATIONSHIP	IF CHILD IS AGE 18-21 ARE THEY IN SCHOOL YES or NO

ADDITIONAL NOTES :

Patient Information – History & Physical (H&P)

PAGE 3 of 4 – Please complete ALL fields

PATIENT NAME: _____ DOB: _____

Reason you need to see a medical provider: _____

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

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.			



Patient Information – History & Physical (H&P)
Page 4 of 4 – 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.

REVOCAION: 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.

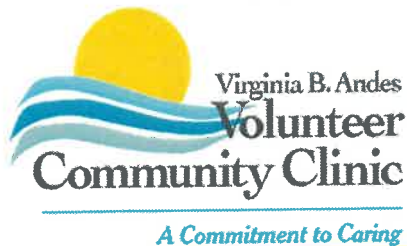
Patient or Legally Authorized Representative Signature

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: ____/____/____



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:** ____/____/____



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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 - * 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.
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- > 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: ____/____/____



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%

FAMILY SIZE	MONTHLY	YEARLY
1	\$3,912	\$46,950
2	\$5289	\$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 CHILDREN 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

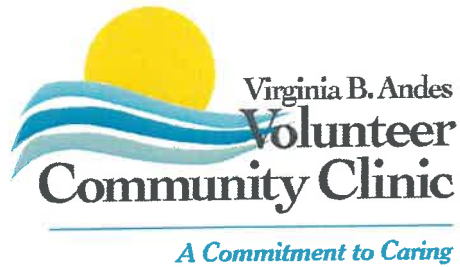


PHOTO ID ATTESTATION

CHECK ONE:

- ☐ I provided a copy of my photo ID when I submitted Part 1 of the Eligibility Packet at my first visit.
- ☐ I am providing a copy of my photo ID with this packet - Part 2.

PROOF OF ADDRESS ATTESTATION

CHECK ONE:

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

CHECK ONE:

- ☐ Photo ID
- ☐ Billing Statement (i.e. electric bill)
- ☐ Lease agreement
- ☐ Pay stub w/address
- ☐ Vehicle Registration
- ☐ Letter from an agency (i.e. Charlotte Cares, JLYM)
- ☐ 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



SS EARNINGS RECORD/1040 ATTESTATION WAIVER

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/Significant Other/Partner, All Children Under 18, And All Children 18-21 Who Are In School

WAYS TO OBTAIN

- 1) Go to the local Social Security Office:
 - > Address: 4054 Beaver Ln, 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 you are 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

*** ABC CHIRITA (MISS) BERNARDI DOOM CINCINNATI OHIO (P-001) ***


NAME: **CHIRITA BERNARDI** AM **DOOM** DOB: **01-01-1954** PG: 001


MONTHLY EARNINGS FOR YEARS REQUESTED

YEAR	EARNINGS	YEAR	EARNINGS	YEAR	EARNINGS
1985	1142.34	1986	2442.41	1987	3470.43
1988	1221.04	1989	18211.39	1990	33518.40
1991	10278.43	1992	2400.93	1993	39719.14
1994	2141.40	1995	2175.45	1996	2013.41

MONTHLY EARNINGS FOR YEARS REQUESTED

MONTHLY EARNINGS FOR YEARS REQUESTED


Chirita Bernardi
 JUN 27 2001
 A05 SSA OHIO


Your Social Security Statement

WANDA WORTHEN October 8, 2001

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. You are currently age 63, based on your work record, you are eligible for retirement benefits. You can start your benefits at any time between age 62 and 66. For each month you wait to start your benefits, your monthly benefit will be higher—the later you wait, the higher your benefit will be.

Disability Benefits
 You have earned enough credits to qualify for disability benefits. If you become disabled before you reach retirement age, you may be eligible for disability benefits. To qualify for disability benefits, you must be unable to do any substantial gainful activity because of a medical condition that prevents you from doing any substantial gainful activity. You must also have a medical condition that is expected to last at least 12 months or result in death.

Survivors Benefits
 You have earned enough credits for your eligible family members to receive survivors benefits. If you die, your family members may be eligible for survivors benefits. The amount of your family member's benefit will depend on their age and whether they are dependent on you for support.

Medicare
 You have earned enough credits to qualify for Medicare at age 65. Medicare is the federal health insurance program for people aged 65 and older. You can enroll in Medicare when you turn 65. If you are already receiving Social Security benefits, you will be automatically enrolled in Medicare Part A (hospital insurance) and Part B (medical insurance).

Supplemental Security Income (SSI)
 You may be eligible for Supplemental Security Income (SSI) if you are aged 65 or older, blind, disabled, and have limited income and resources. SSI is a federal cash benefit that helps pay for food, clothing, shelter, and medical care. You may also be eligible for Medicaid if you are eligible for SSI.

Other Information
 For more information about Social Security, visit www.ssa.gov or call 1-800-772-6246. You can also visit your local Social Security office.

Earnings and Not Covered by Social Security
 You may also have earnings from work not covered by Social Security. This includes earnings from self-employment, or from work in a foreign country, state, or local government or in a foreign country.

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 government benefits to make sure you have enough to live on in retirement.
 • Your benefit at least 10 years of work (or 40 credits) is based on your highest 35 years of earnings. If you have more than 35 years of earnings, your benefit will be based on the highest 35 years of earnings.
 • Use the cost of living adjustments to your benefit will keep up with inflation.
 • The age you start benefits will affect the benefit amount. The earlier you start, the lower your benefit will be.
 • If you get retirement or disability benefits, your spouse and dependent children may qualify for benefits.
 • If you are disabled and receive benefits for 10 years, you may be able to receive benefits on your spouse's record, if your spouse is eligible to receive benefits on your record, that does not affect your or your spouse's benefit amount.
 • When your equity for either retirement or disability benefits, you may be required to pay for the cost of health care.
 • For more information about benefits, visit www.ssa.gov or call 1-800-772-6246.

Earnings and Not Covered by Social Security
 You may also have earnings from work not covered by Social Security. This includes earnings from self-employment, or from work in a foreign country, state, or local government or in a foreign country.

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 government benefits to make sure you have enough to live on in retirement.
 • Your benefit at least 10 years of work (or 40 credits) is based on your highest 35 years of earnings. If you have more than 35 years of earnings, your benefit will be based on the highest 35 years of earnings.
 • Use the cost of living adjustments to your benefit will keep up with inflation.
 • The age you start benefits will affect the benefit amount. The earlier you start, the lower your benefit will be.
 • If you get retirement or disability benefits, your spouse and dependent children may qualify for benefits.
 • If you are disabled and receive benefits for 10 years, you may be able to receive benefits on your spouse's record, if your spouse is eligible to receive benefits on your record, that does not affect your or your spouse's benefit amount.
 • When your equity for either retirement or disability benefits, you may be required to pay for the cost of health care.
 • For more information about benefits, visit www.ssa.gov or call 1-800-772-6246.

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 **2024** OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

For the year Jan. 1–Dec. 31, 2024, or other tax year beginning , 2024, 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
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.

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 ☐ You ☐ Spouse

Filing Status ☐ Single ☐ Head of household (HOH)
☐ Married filing jointly (even if only one had income)
☐ Married filing separately (MFS) ☐ Qualifying surviving spouse (QSS)
Check only one box. 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:
☐ If treating a nonresident alien or dual-status alien spouse as a U.S. resident for the entire tax year, check the box and enter their name (see instructions and attach statement if required):

Digital Assets At any time during 2024, 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, 1960 ☐ Are blind Spouse: ☐ Was born before January 2, 1960 ☐ Is blind

Dependents (see instructions):

(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
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

If more than four dependents, see instructions and check here ☐

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	
3a	Qualified dividends	3a	
4a	IRA distributions	4a	
5a	Pensions and annuities	5a	
6a	Social security benefits	6a	
b	Taxable interest	2b	
b	Ordinary dividends	3b	
b	Taxable amount	4b	
b	Taxable amount	5b	
b	Taxable amount	6b	
c	If you elect to use the lump-sum election method, check here (see instructions)		<input type="checkbox"/>
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, \$14,600
• Married filing jointly or Qualifying surviving spouse, \$29,200
• Head of household, \$21,500
• 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 (2024)

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:	Gra W. DiAmato	Pay Period Start:	08/01/2023
Address:	4462 Selah Way South Burlington, VT 05403	Pay Period End:	08/31/2023
Employee ID:	100025482	Issue Date:	09/03/2023
Department:	Research & Development	SSN:	5024-XXXX
		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%	\$508.00		\$71.83	
	Federal Income Taxes	\$2,356.00		\$256.00	
	Social Security	\$1,380.00		\$150.00	
	State Tax	\$450.00		\$50.00	
	Insurance	\$160.00		\$40.00	
	Loans	\$5,580.00		\$605.00	
	TOTAL DEDUCTIONS	\$10,694.00		\$1,172.83	

CHECK ONE:

☐ 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



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	Ref Nbr:	Date Credited	Amount
Deposit	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

CHECK ONE:

____ I have attached the most recent statement/s

____ I do not have any bank accounts

PATIENT SIGNATURE

Date



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
Maximum Benefit Amount:	\$0	Earnings Disregard:	\$58.00
Monetary Status:			Pending
File Date:			03/19/2020
Requested Benefit Payment Information			
Last Week Signed:	3/22/2020 - 3/28/2020	Waiting Week:	
Last Week Paid:		Service Language:	English
Current Program Type:			Regular UC
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.

CHECK ONE:

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

To: Mr. & Mrs.
JONATHAN DOE
1234 MAKEBELIEVE LANE
AKRON, OH 44312

Re:

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.

CHECK ONE:

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

PATIENT SIGNATURE

Date

NOTICE

MEDICATION ALERT – UNABLE TO DISPENSE

RE: INSURANCE COVERAGE & INCOMPLETE ELIGIBILITY PACKETS

Many of our pharmaceutical companies who donate medications to us require that our patients do not have insurance coverage or incomplete eligibility packets. Our records indicate that you presently have insurance coverage or have an incomplete eligibility packet; therefore, we are unable to dispense their medications to you until your insurance coverage is no longer reflected in our system and/or your eligibility packet is complete.

Please contact Judy Barclay with any questions and/or updates.

Her contact information is.....

Phone: 941-766-1584 x129

Email: jbarclay@volunteercare.org