Virginia B. Andes Volunteer Community Clinic
A Commitment to Caring

ELIGIBILITY PACKET PICKUP NOTES

NOTE: YOU MUST HAVE AN APPOINTMENT TO BRING IN YOUR PAPERWORK. IT CAN NOT BE DROPPED OFF.

> REQUIREMENTS:
- FULL TIME CHARLOTTE COUNTY RESIDENT
- NO INSURANCE
  (i.e. MEDICARE, MEDICAID, SHARE OF COST, COMMERCIAL)
- 300 % OR LESS OF FEDERAL POVERTY GUIDELINES

> TAKE ELIGIBILITY PACKET HOME AND COMPLETE ALL FIELDS ON ALL PAGES, INCLUDING SIGNING AND DATING WHERE REQUESTED

> GATHER ALL SUPPORTING FINANCIAL DOCUMENTATION THAT IS APPLICABLE FOR YOU

> WHEN PAPERWORK IS COMPLETED AND ALL REQUIRED DOCUMENTATION GATHERED, PLEASE CALL THE CLINIC TO MAKE A SCREENING APPOINTMENT

> SCREENING APPOINTMENT TIMES ARE……
MONDAY > 9 AM, 10 AM, 11 AM, 12 PM
TUESDAY > 9 AM, 10 AM, 11 AM, 12 PM
WEDNESDAY > 9 AM, 10 AM, 11 AM, 12 PM
THURSDAY > 10 AM, 11, AM, 12 PM, 1 PM
FRIDAY > 9 AM, 10 AM, 11 AM, 12 PM

> FOR APPOINTMENTS, CALL 941-766-9570

> FOR QUESTIONS, CALL OR EMAIL THE ELIGIBILITY TEAM
941-766-9570 x129 or x142
OR
eligibilityteam@volunteercare.org

NOTE: YOU MUST HAVE AN APPOINTMENT TO BRING IN YOUR PAPERWORK. IT CAN NOT BE DROPPED OFF.

Virginia B. Andes Volunteer Community Clinic
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Patient Information – History & Physical (H&P)

DEMOGRAPHICS - 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 #: ☐ Home ☐ Cell
Email Address:		Interested in Telehealth Services: ☐ Yes ☐ No
Communication Barriers: ☐ Vision ☐ Hearing ☐ Reading ☐ Writing ☐ Other_____	Language Preference: _____	Translator Required: ☐ Yes ☐ No

CHECK PREFERRED PHARMACY: _____ VBA CLINIC ON OLEAN _____ MOBILE CLINIC

☐ Male ☐ Female	Relationship Status: ☐ Single ☐ Married/Significant Other ☐ Other	# of Children living at home: > Ages 0-17 _____ > Ages 18-21 **AND** are In school _____

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	☐ Sickle Cell Anemia	☐ Cancer

Height: _____ Weight: _____

Employer: _____ Occupation: _____

How were you referred to the VBA:_____

****

FOR OFFICE USE ONLY: ***PATIENT ID #:*** _____ ***Eligibility Expires:*** _____

Patient Type: ☐ ***Clinic*** ☐ ***Bus*** ***Housing Status:*** ☐ ***Housed*** ☐ ***Unhoused***

Employment Status: ☐ ***Employed*** ☐ ***Unemployed***

Eligibility Packet: ☐ ***Incomplete > Date:***_____ ☐ ***Complete > Date:*** _____

Insurance:

MEDICARE > ☐ ***NOT Checked*** ☐ ***Checked*** ☐ ***Has Insurance*** ☐ ***Does Not Have Insurance***

COMMERICAL/MEDICAID > ☐ ***NOT Checked*** ☐ ***Checked*** ☐ ***Has Insurance*** ☐ ***Does Not Have Insurance***

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Patient Information – History & Physical (H&P)

FAMILY UNIT WORKSHEET – Page 2 of 4 – Please complete ALL fields
> 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 :

_____

_____

Virginia B. Andes Volunteer Community Clinic
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Patient Information – History & Physical (H&P)

MEDICAL - 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
☐ 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.			

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Patient Information – History & Physical (H&P)

PREVIOUS MEDICAL RECORDS - Page 4 of 4 – Please complete ALL fields

PATIENT NAME: _____ DOB: _____

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:

_____

_____

_____

Virginia B. Andes Volunteer Community Clinic
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MEDICAL RECORDS REQUEST
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 2 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

Virginia B. Andes Volunteer Community Clinic

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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
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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

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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**.

2026 FEDERAL POVERTY GUIDELINES – 300%

FAMILY SIZE	MONTHLY	YEARLY
1	$3,990	$47,880
2	$5,410	$64,920
For each additional person, add	$1,420	$17,040

BELOW ITEMS ARE REQUIRED FOR PATIENT ONLY:

> **ATTESTATION - Photo Identification – i.e. Driver License, Passport, Government ID Card – Page 9**
> **(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 9**
> ***(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 10**
> *Example - Current Social Security Statement (Earnings Record) Example – Page 11*
> *Example - Previous year Complete Income Tax Return (Form 1040) Example – Page 12*
> **ATTESTATION - Most recent 30 days/1 month of current pay stubs/self-employed earnings – Page 13**
> **ATTESTATION - Most recent 30 days/Current Bank Statements (all checking & savings) - Page 14**
> **ATTESTATION – Unearned Income/Current Unemployment letter stating amount to be received - Page 15**
> **ATTESTATION - Unearned Income/Current Proof of Award Letter stating amount to be received (i.e.retirement, disability, dependents, survivors, veteran benefits - Page 15**

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PATIENT NAME: _____ **DOB:** _____

PHOTO ID ATTESTATION

CHECK ONE:

_____ I am providing a copy of my photo ID with this packet

****

PROOF OF ADDRESS ATTESTATION

CHECK ONE:

_____ I attest that I am providing one of the following documents as written proof of my Charlotte County residency……

__Photo ID __Bill __Lease __Pay Stub __Vehicle Registration

__Other (Description _____)

_____ 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

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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

Virginia B. Andes Volunteer Community Clinic
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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***

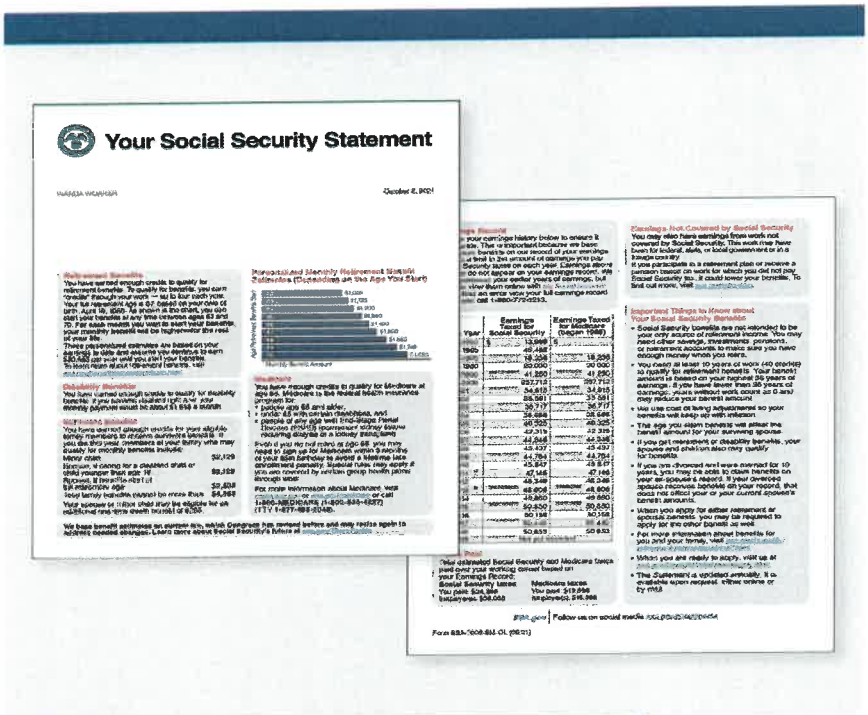
WAYS TO OBTAIN

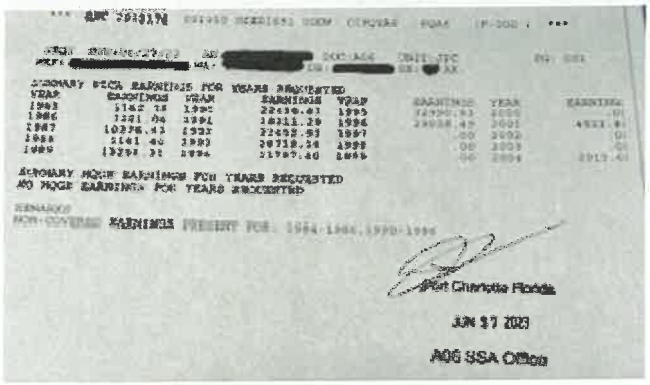
1) Go to the local Social Security Office:
   > Address: 4054 Beaver Ln, Port Charlotte, FL 33952
   > Phone #s: Local # > 877-405-0490 or National # > 800-772-1213

   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





Virginia B. Andes Volunteer Community Clinic
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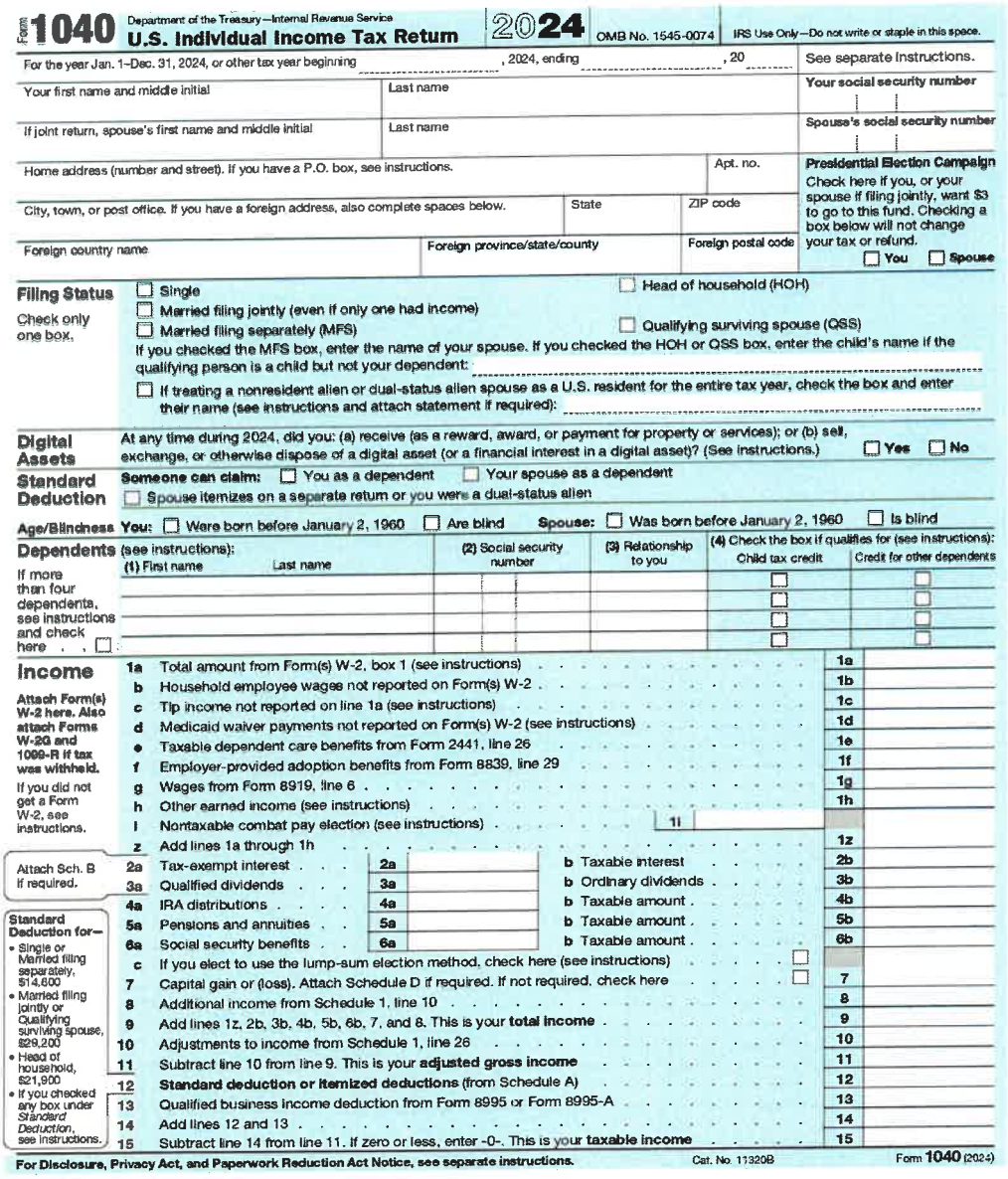
EXAMPLE - PREVIOUS YEAR *COMPLETE* INCOME TAX RETURN (FORM 1040)

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. ☐ You ☐ Spouse

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

Filing Status Check only one box.
☐ Single ☐ Head of household (HOH)
☐ Married filing jointly (even if only one had income)
☐ Married filing separately (MFS) ☐ 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:
☐ 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): 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, $14,600
- Married filing jointly or Qualifying surviving spouse, $29,200
- Head of household, $21,900
- 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)

Virginia B. Andes Volunteer Community Clinic
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PATIENT NAME: _____ **DOB:** _____

EARNED INCOME ATTESTATION

MOST RECENT 30 DAYS
1 MONTH OF CURRENT PAY STUBS/SELF-EMPLOYED EARNINGS

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:	6462 Selah Way South Burlington, VT 05403	Pay Period End:	08/31/2023
		Issue Date:	09/03/2023
Employee ID:	100025462	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

Mark 1 applicable box with an "X" for each person

OPTIONS	PATIENT	SPOUSE/PARTNER	CHILD (16-21)
1 month current pay stubs attached			
Self-Employed/see below attestation statement			
Zero earned income			

In the last 30 days, being self-employed, I attest that I made the following: _____

_____ _____

PATIENT SIGNATURE ***Date***

Virginia B. Andes Volunteer Community Clinic

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PATIENT NAME: _____ **DOB:** _____

BANK (CHECKING/SAVING) STATEMENTS MOST RECENT 30 DAYS

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

Mark 1 applicable box with an "X" for each person

OPTIONS	PATIENT	SPOUSE/PARTNER	CHILD (16-21)
Most recent checking/savings statements attached			
Do not have any checking/savings accounts			

_____ _____

PATIENT SIGNATURE ***Date***

Virginia B. Andes Volunteer Community Clinic
A Commitment to Caring

PATIENT NAME: _____ **DOB:** _____

UNEARNED INCOME ATTESTATION

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.

OPTIONS	PATIENT	SPOUSE/PARTNER	CHILD (16-21)
Unemployment Award Letter attached			
Do not receive			

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

Social Security Administration
Benefit Verification Letter

Date: January 30, 2025
BNC#: 25L0961F50530
REF: A DI

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 2024, the full monthly Social Security benefit before any deductions is $[redacted]

We deduct $[redacted] for medical insurance premiums each month.

The regular monthly Social Security payment is $[redacted]
(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 third of each month.

We found that you became disabled under our rules on November 30, 2018.

Information About Past Social Security Benefits

From December 2023 to November 2024, the full monthly Social Security benefit before any deductions was $[redacted]

We deducted $[redacted] for medical insurance premiums each month.

The regular monthly Social Security payment was $[redacted]
(We must round down to the whole dollar.)

Type of Social Security Benefit Information

You are entitled to monthly disability benefits

OPTIONS	PATIENT	SPOUSE/PARTNER	CHILD (16-21)
Award Letter attached (i.e. SS, Pension, VA, etc)			
Do not receive			

_____ _____

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:** ___/___/___

PATIENT COPY

Virginia B. Andes Volunteer Community Clinic

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NOTICE

IF YOU HAVE INSURANCE COVERAGE
OR
IF YOUR ELIGIBILITY PACKET IS INCOMPLETE

YOU WILL HAVE *LIMITED ACCESS* TO

MEDICATIONS & PROVIDER SERVICES

UNTIL INSURANCE COVERAGE NO LONGER

SHOWS AND/OR YOUR ELIGIBILITY PACKET IS COMPLETE

NOTE: YOU HAVE 30 DAYS FOR INSURANCE TO BE CANCELLED AND/OR FOR THE ELIGIBILITY PACKET TO BE COMPLETED AFTER WHICH YOUR ACCOUNT WILL BE INACTIVATED.

Please contact the Eligibility Team with any questions and/or updates. Their contact information is.....
Phone: 941-766-9570 x129 or x142
Email: eligibilityteam@volunteercare.org

8/28/26