PATIENT ELIGIBILITY APPLICATION

Ann Silverman Community Health Clinic ♦595 West State Street ♦ Doylestown, Pennsylvania 18901
Phone: 215-345-2260 ♦ Fax: 215-489-7236

Head of Household: _____ Date of Birth: ____/____/____
(Last name) (First Name) (Middle initial) month/day/year

Phone Number: _____Application Date: ____/____/___

The Ann Silverman Community Health Clinic provides free medical and dental care, and behavioral health and social services to qualified low-income, uninsured residents of Bucks County. To qualify, you cannot have any insurance or have access to any insurance (including but not limited to Medicare, Medicaid, Private Insurance, etc).
Eligibility is usually for one year, although there are some instances when a shorter time period is necessary or when your eligibility status changes. You will be advised of our decision and it your responsibility to submit a re-eligibility application prior to your expiration date.

- Provide the names and income for each individual that live in your household, whether or not they are related to you or not, and indicate if they are also applying for clinic services.

- Provide the following for <u>all</u> persons who are applying to the clinic for services:
  Proof of Identity. Acceptable proof includes:
  - ➢ Passport, Birth Certificate, Driver's license, or other Photo ID

  Proof of Residency for <u>ALL</u> adults listed on application:
  Acceptable proof includes:
  - ➢ Telephone or utility bill (water/sewer/gas/oil/electric)
  - ➢ Property Tax bill or lease with <u>your name and current address</u>
  - ➢ Ordinary mail and Driver's License are not acceptable

- Provide the following for <u>all</u> persons who live in your household.
  Proof of income includes:
  - ➢ **<u>the last four (4) pay stubs or a letter from employer(s)</u>**
  - ➢ if self-employed, profit and loss statement for each of the last three (3) months
  - ➢ proof of child support or alimony or court orders for child support
  - ➢ letter from unemployment, worker's compensation, SSD, SSI, etc.

  Three most recent bank statements.

Missing information will result in a delay in your approval for clinic services.
IF self-employed, we may ask you for additional documentation

OFFICE USE ONLY

Date of review: By:	Date of determination: By:
# Adults _____ # Children _____ Children Insured Y N How Many Children Insured_____ Monthly Income_____Source:_____	
□ INELIGIBLE Reason:	

Items Required: _____

HOUSEHOLD FINANCIAL ASSESSMENT

I. **List your** name and **every** person who will live in your household **continuously** for the next 12 months. This includes EVERYONE (related/unrelated)

FULL Name (last, first middle)	Age	DOB (M/D/Y)	Country of Birth	Relationship to Head of Household	Employed? Y or N
				SELF	

II. INCOME - Names of every person in the household who works and their weekly BEFORE TAX wages. You must provide proof of all income in the household.

FULL Name (Last, First, Middle)	Place of Employment	# Hours worked in a week	Hourly wage Seasonal?	Is anyone Self-Employed?

- **Do you, or does anyone in your household, receive child support?** Yes _____ No _____

Amount per week	For (child's name)

List the amount received for each child.

- **Do you, or does anyone in your household, receive a pension, Social Security, Workers Compensation, Unemployment, alimony or any other source of income?** Yes ____ No____

List who receives it, how much, and how often it is received (for example $/wk, $/month.)

Name	Pension	Social Security	Workmen's Compensation	Unemployment	Alimony	Other

- **Amount of rent or mortgage paid monthly _____**

PLEASE READ AND SIGN

1. I have provided true information about every person who lives in my household.
2. I understand that failure to provide true information may result in terminating me from the Clinic, which will include

medical & dental care and medications.

3. **I agree to tell the clinic about any insurance and income changes for me and my family.**

YOUR SIGNATURE_____

DATE SIGNED_____

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Date_____
Patient's Name_____
Address _____City_____
Apt Number _____State_____Zip Code_____Po Box (if different)_____
Birthdate (Month/Day/Year_____Age_____
Home Phone_____Cell Phone_____
Race_____Ethnicity _____Preferred Language_____

If applicant is a Minor, please provide
Parent/Guardian Name_____
Parent/Guardian Address_____
Parent/Guardian Birthdate_____Phone_____

Emergency Contact
Name_____Phone_____
Relationship to you_____Birthdate_____

Please answer the following:

1) Do we have permission to leave a voice mail message on your voicemail or answering machine regarding your personal health information or to confirm appointments? YES OR NO
2) Do we have permission to text you appointment reminders? YES OR NO
3) If we cannot reach you, may we speak to your emergency contact? YES OR NO
4) Are you or is anyone in the household a Veteran? YES OR NO

What Pharmacy do you prefer?
Name
Address
Phone
Fax

Promises to the Ann Silverman Community Health Clinic:

- As a patient of the Ann Silverman Community Health Clinic, you promise to make every effort to show up for any/all of your appointments (whether they are onsite or scheduled offsite). In addition, if you are unable to attend any appointments you will contact the office (215-345-2260) at least 24 hours prior to your appointment time. After 3 no/shows, we reserve the right to refuse to schedule further appointments.

- You will make every effort to complete yearly applications and provide requested documents so that we can provide you and your family with continued care. In addition, you must notify us of any changes in your income/living arrangements or insurance changes immediately.

Signature of Patient_____Date_____
Print Patient Name_____

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Authorization for Treatment Services (Medical/Dental/Behavioral Health and Social Work)

FULL NAME OF PATIENT _____ DATE OF BIRTH _____

1. I hereby authorize medical/dental/behavioral health and social work treatment by the Ann Silverman Community Health Clinic.

2. I understand that the services I receive may be provided by volunteer physicians, physician assistants, nurses, nurse practitioners, dentists, and dental hygienists, psychologist, medical social workers and licensed professional counselors that are licensed to practice, as required, in Pennsylvania.

3. I understand that emotional and spiritual support is provided by an unlicensed patient navigator.

4. I retain the right to seek treatment elsewhere, at any time, at my own expense.

5. I agree to follow the recommendations given to me by the medical/dental/behavioral health and social work healthcare providers and or staff of the ASCHC and I will ask questions if I do not understand information provided to me.

6. I will notify the staff of any changes in my medical condition, financial status or living arrangement.

7. I understand that in order to provide quality services it may be necessary for the staff to communicate with and refer to other resources. I understand that I may be asked to provide written consent to the release of certain medical/dental information. I retain the right to withdraw the consent at anytime by notifying the Ann Silverman Community Health Clinic either verbally or in writing.

8. I understand that if I have any questions or concerns about this or any other form or any services, I may ask to meet with the Clinic Manager at the Ann Silverman Community Health Clinic.

9. I understand that as a patient in the Ann Silverman Community Health Clinic, my medical and confidential information will be added into eCW (eClinicalWorks). eCW is an electronic medical record, practice management and personal health record software and services to hundreds of thousands healthcare providers. The Clinic will include your medical record within the eCW platform so it will be available to any physician member of the eCW who is treating you.

10. I understand that, if I am not satisfied with any decisions of the staff, I may appeal the decision to the Executive Director of the Ann Silverman Community Health Clinic. In her/his absence, the Medical Director, or the current Board Chair will handle the appeal.

SIGNATURE OF PATIENT _____

DATE_____

If patient is a minor, under 18 years of age, parents or legal guardian must sign below:

Signature of Parent/Guardian _____ DATE _____
Relationship to patient (mother/father/guardian, etc.): _____

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Does anyone listed **have insurance** or have **access to any insurance** plan including but not limited to: Medical Assistance, Medicare, VA, CHIP, Private Medical or Dental Insurance?
Yes____ No____
If yes, list name of person and include copy of front and back of insurance card
_____
_____
_____

Does anyone listed have the opportunity to obtain medical insurance through his/her employer?
Yes ___ No____
If yes, list name of person, employer's name and type of insurance that is available
_____
_____
_____

_____ _____
Signature **Date**