PATIENT ELIGIBILITY APPLICATION

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

Name of Applicant: ____ 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 care, dental care and behavioral health services for uninsured people who live in Bucks County and have a limited income. To qualify you cannot have any insurance (including but not limited to Medicare, Medicaid, and Supplement etc).

- 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:
    - ➢ Any government issued photo ID or Passport
    - ➢ Driver's license, passport, or permanent resident alien card.
    - ➢ Birth certificates must be used for individuals that do not have a photo ID
  - **Proof of Residency**. Acceptable proof includes:
    - ➢ Telephone or utility bill (water/sewer/gas/oil/electric)
    - ➢ Tax bill or lease with <u>your name and current address</u>
    - ➢ Ordinary mail or bank statements 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.
    - ➢ letter(s) of support from family or friends that are assisting individuals in the household
  - **Most recent Federal** (<u>Not State</u>) **Income Tax returns and W2.**

Missing information will result in a delay in your approval for clinic services.
Eligibility is re-evaluated every 12 months.
IF self-employed, we may ask you for additional documentation (including bank statements).

OFFICE USE ONLY

Date of review: By:	Date of determination: By:
☐ APPROVED FOR ONLY Medical______ Dental______ S/W_______	
☐ APPROVED All Clinic Services	
# Adults _____ # Children _____ Children Insured Y N How Many Children Insured____________ Monthly Income_________Source:_________________Proof of Residency Y N Proof of Identity Y N	
☐ INELIGIBLE Reason:	

Additional Documents Needed Y N ____Initial Notified Patient Y N _____Initial Items Required____

HOUSEHOLD FINANCIAL ASSESSMENT

I. List your name and **every** person who live in your house/apartment. EVERYONE (related/unrelated)

☑	FULL Name (last, first, middle)	Age	DOB-(Month, Day, Year)	Is everyone Insured? YES OR NO
☐				
☐				
☐				
☐				
☐				
☐				

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	Is anyone Self-Employed

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

  List the amount received for each child.

Amount per week	For (child's name)

- **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** ____
- **Name of Individual you pay your monthly rent/mortgage to** __________________________
- **DO YOU OR ANYONE IN THE HOUSEHOLD RECEIVE PA MEDICAL ASSISTANCE Y OR N**
- **IF SO, PLEASE PROVIDE NAMES (and copy of card)**__________________________________

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**

Ann Silverman Community Health Clinic
PLEASE PRINT CLEARLY

Date__________________
Patients Name____
Address ____Town___________________________
State__________________Zip Code___________________Po Box (if different)______________________
Birthdate (Month/Day/Year__________________________________Age____________________________
Home Phone____________________________________Cell Phone______________________________
Pronoun____________________Race_____________________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) Do you have any medical or dental insurance that you have not disclosed? YES OR NO
4) If we cannot reach you, may we speak to your emergency contact YES OR NO
5) Are you or is anyone in the household a Veteran YES OR NO
6) Is this visit related to an accident of any kind on the job or injury in a vehicle? YES OR NO
   IF SO explain____
7) What Pharmacy do you prefer:
   a. Name
   b. Address
   c. Phone
   d. Fax

Promises to the Ann Silverman Clinic:

- As a patient of the Ann Silverman 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/all appointments you will contact the office (215-345-2260) immediately to let us know that you will not be coming; otherwise, there is a possibility that you will be billed for a no/show.

- 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____

ANN SILVERMAN
COMMUNITY
HEALTH CLINIC

Caring for the Community

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.

PLEASE SIGN

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.): ____