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**ELIGIBILITY NOTIFICATION**

Sacred Heart Community Clinic

620 Round Rock West Drive #8, Round Rock, TX 78681

Office: (512) 716-3929

Fax: (512) 716-3998

In order to determine your eligibility, you MUST complete your registration. We need the following items. **Registration packet must be completed before turning in for review.** Our services are FREE but all patients are asked to make a donation at each visit if possible.

\_\_\_\_\_**Complete Intake packet**

**\_\_\_\_\_Photo ID, Driver’s license, Passport**

**\_\_\_\_\_Proof of income or a financial support statement**

**\_\_\_\_\_Current utility bill to show you live in Williamson Co. (does not need to be in your name)**

**\_\_\_\_\_Complete a financial screening either in person or over the phone with a clinic staff member.**

Approval period will be for 1 year period unless eligibility changes (acquires insurance, Medicare, Medicaid, or over income). Feel free to contact the clinic with questions.

During the financial screening, you might be told that you may qualify for the Williamson Co Indigent Care Program called WILCO CARES. This program will cover up to about $30,000.00 of medical needs in a 12-month period at local hospitals, doctor’s offices, CPL labs, and ARA x-ray facilities. SHCC will continue to see you. WILCO will then take over the medical cost of our services. It may take 60 days to process the application for this program. DO NOT waste time applying.

Thank you for reaching out to SHCC. Our goal is to help you stay healthy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TODAY’S DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient’s Name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient’s signature)

 1/4/24

|  |  |  |
| --- | --- | --- |
|  |  | STAFF USE ONLY: PRN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ELIGB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# (Circle one): New Patient Renewing Patient

## Applicant Information (as appears on ID)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | Date: |  |
|  | Last | First | M.I. |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| □ US Citizen □ Permanent Resident □ Visitor □ Other:  |  |  |  |
| Social Security No.  |  |  | Date of Birth:  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Language: □ English □ Spanish □ Both □ Other: |  |  | Sex: □ Male □ Female  |

## Contact Information

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address | Apartment/Unit # |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  | City | State | County | ZIP Code |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Mobile Phone:  |  | Phone:  |  |  | □ work □ home |
| Email:  |  |  |  |  |

##  Demographics

|  |
| --- |
| Veteran (check one): □ Yes □ No |
| Marital Status (check one): □ Single □ Married □ Divorced □ Widowed □ Common Law □ Separated |
| Ethnicity (select one): □ Hispanic or Latino □ Non- Hispanic or Latino |  |  |
| Race (select one): □ American Indian □ Asian □ Black □White □ Other:  |  |  |
| Work Status (check one): □ Unemployed □ Disabled □ Spouse Works □ Part-time Job □ Full-Time Job □ Supported By Family/Friends (fill in support statement) |
| Number of Adults in Family:  |  |  Number of Children under the age of 19: |  | Annual Income: |  |

##  Next of Kin

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Last Name: |  |  |  |
| Relationship to Patient (check one): □ Spouse □ Parent □ Sibling □ Child □ Partner □ Other \_\_\_\_\_\_\_\_\_\_\_   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Address:  |  |  | Apartment #: |  |  |
| City:  |  | State:  |  | Zip:  |  | County:  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone Number:  |  | □ cellphone □ home phone  |  |

## Medical Release and Emergency Contact

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Authorization to Release Medical Information to:**  |  |  | Relationship: |  | Phone Number: |  |
|  | *First name*  | *Last Name*  |  |  |
| **Emergency Contact**: |  |  | Relationship: |  | Phone Number:  |  |
|  | *First Name* | *Last Name* |  |  |
| Where did you hear about SHCC |  |  |  |  |

# Income Declaration and Fraud Statement

|  |
| --- |
| **Patient Information** |
| Patient Name: |  |  |  | Date: |  |
|  | First | M.I | Last |  |  |
| Social Security Number:  |  | Date of Birth:  |  |
|  |  |  |  |

|  |
| --- |
| **Income Screening Tool** |
| Total Household Income: |  |  □Monthly □ Annually |
| How is the Income Made?  |  |
| Number of adults in the household:  |  | Number of Dependents in the Household:  |  |
| List the age of all the dependents: |  |
| OFFICE USE ONLY (TOTAL #): |  |
| Patient’s Initials: |  |  | Screener’s Initials:  |  |
|  |  |  |  |  |

|  |
| --- |
| **Fraud Statement** |
|  I,  |  | , do hereby affirm that the income I declared is correct and be verified if necessary.  |
| * If my income should change, due to loss of job, new employment or income received from any source, I agree to report the change to the clinic where I receive health care.
* I understand that failing to report employment or income from any source could result in civil or criminal penalties. I may also be held responsible for full payment for any medical services received at the clinic.
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| --- | --- | --- | --- |
| **Signatures** |  |  |  |
| Patient Name (Printed):  |  | Date:  |  |
| Patient Signature:  |  |  |  |
|  |  |  |  |

SHCC Consent and Waiver Form

I have requested medical, dental or mental health services and/or advice from medical or dental professionals at Sacred Heart Community Clinic. In return for such services or advice, I agree to the following:

I understand that Sacred Heart Community Clinic is here to provide free medical, dental or mental health care to those who qualify under its guidelines. I believe that I qualify under the guidelines. I give my consent to SHCC (Medical and Dental clinics) for both staff and volunteers to the following: Examine, Diagnose, and Treat my medical/dental/mental conditions. It is my responsibility to update my contact information with the clinic.

I understand that SHCC abides by federal **HIPAA Confidentiality** regulations. I understand that my medical and dental information will be used and disclosed between the medical and dental clinics of SHCC. I, also, understand that I may request a copy of SHCC’s HIPAA disclosure at any time by asking the front desk staff for a copy.

I understand that SHCC may communicate with me through text messages to my phone, leave voice messages on my phone, and send emails to my email address. **Initial ALL lines that applies**

* 1. \_\_\_\_\_\_\_\_ SHCC can leave a voice message
	2. \_\_\_\_\_\_\_\_ SHCC can text message my cell phone on record

**NO SHOW POLICY: Due to the demand for services and limited resources, I understand the following policy.**

* 1. **Scheduled appointments- If I have 3 NO SHOWS in a year (Medical and/or Dental), I will no longer be able to make appointments in advance. I will need to call for same day appointments if available.**
	2. **If I need to cancel an appointment, I will give the clinic 24 hours’ notice so my appointment slot may be filled by someone else. Otherwise, it MAY be marked as a NO SHOW.**

MEDICATION REFILLS: I understand my refills are filled at my scheduled appointments. I will contact the nurse if my medications will run out before my next appointment. If I have medications that come directly from a pharmaceutical company, I will call the front desk and reorder at least 3 weeks prior to needing the medication.

Tele-video Appointment Consent: **Initial the line that applies** (a copy of policy available at clinic)

\_\_\_\_\_I agree to participate in tele-video visits with my provide.

 \_\_\_\_\_I DO NOT wish to participate in tele-video visits with my provider.

I have been given an opportunity to ask questions I may have about this form before signing below.

MALPRACTICE INSURANCE: SHCC Participates in the federal Tort Claims Act

FTCA Malpractice Insurance Statement: To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act(FTCA), (See 28 U.S.C §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health practitioner, board member, officer, employee, or independent contractor who have provided a required or authorized service under the Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C § 233(a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals and providing care services to patients at this free clinic.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Full Name Patient’s Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Today’s Date

Sacred Heart Community Clinic Patient Health Information

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name:  |  | Today’s Date :  |  |

 Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| What is the reason for your visit today? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| What medications are you on? (List below) | What is the dose of the medication? | How many times a day do you take the medication? | How long have you been on the medication? |
|  |  |  |  |
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|  |  |
| --- | --- |
| Are you allergic to any medications? List any below.  | What is your allergic reaction to the medication listed? |
|  |  |
|  |  |

|  |  |
| --- | --- |
| Have you ever had a surgery? | □ yes □ no |
| If yes, list the type of surgery below.  | List the year or age of the surgery below.  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| Have you ever been hospitalized?  | □ yes □ no |
| If yes, list the reason for the hospitalization below.  | List the year or age of the hospitalization below.  |
|  |  |
|  |  |
| Ongoing Medical Problems for the Patient:  |  |

|  |
| --- |
| Has anyone on your family been diagnosed with the following: (check yes or no for each one) |
| Diabetes:  | □ yes □ no | If yes, then who? |  |
| Heart Disease:  | □ yes □ no | If yes, then who? |  |
| High Blood Pressure:  | □ yes □ no | If yes, then who? |  |
| Cancer:  | □ yes □ no | If yes, then who? |  |
| What type of cancer? ( if you answered yes):  |  |
| Other:  | Who in the family? |

|  |  |
| --- | --- |
| Do you smoke? □ yes □ no | If yes, how many packs per week? |
| Former Smoker? □ yes □ no | If yes, when did you quit?  |
| Do you drink? □ yes □ no | If yes, circle one: Daily Weekly Monthly Rarely |

 WilCO Financial Support Statement

To be filled out only if you have no income **OR** theutility bill is not in you or your spouse’s name.

 **STATEMENT OF SUPPORT FOR:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_

**Assistance Provided** (to be filled out by the person who is providing support)

 □ I provide food and/or shelter but do **not provide any cash assistance**.

□ I help with personal expenses (rent, utilities, car payments/insurance, clothes, phone, etc.) P**lease indicate how you help \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

□ I make payments directly to creditor for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I give client $ \_\_\_\_\_\_\_\_ a month to make payments for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **and do not expect to be repaid.**

□ I loan client $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **a month and do not expect to be repaid.** Explain your agreement about how and when you will be repaid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////////**

The above household □ **DOES** □ **DOES NOT** live with me/us. He /She has lived with me/us since \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( Best estimate of date)

Person providing support (Please print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_