SACRED HEART
COMMUNITY CLINIC

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 must be completed within 14 days.**

_____**Complete Intake packet**
_____**Photo ID, Driver's license, Passport**
_____**Proof of income or a financial support statement**
_____**Current utility bill or rental agreement to show you live in Williamson Co.**
_____Complete a financial screening either in person or over the phone with a clinic staff member.

During this time, you may use our services for a 30-day period, which ends (date) _____. After this date, you risk losing your eligibility at the clinic if your registration is not complete. If you are approved it will be for a 1 year period. Feel free to contact the clinic with questions.

During the financial screening, you may be told that you may qualify for the Williamson Co Indigent Care Program called WILCO. This program will cover up to about $30,000.00 of medical needs in a 12-month period. SHCC will see you for 60 days of medical care while you apply. WILCO will then take over your medical care or SHCC will continue taking care of you provided you show SHCC your denial letter from WILCO. It may take 45 days to process the application for this program DO NOT waste time.

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

_____ TODAY'S DATE_____
(Patient's Name)

_____ _____
(Patient's signature) (Staff signature)

11/09/23

SACRED HEART COMMUNITY CLINIC

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

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 ☐ Caregiver
☐ Friend ☐ Relative

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 our clinic? _____

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.

Signatures

Patient Name (Printed): _____ Date: _____

Patient Signature: _____ Witness Signature: _____

Sacred Heart Community Clinic
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:

1. 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.

2. 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.

3. 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**
   a. _____ SHCC can leave a voice message
   b. _____ SHCC can text message my cell phone on record
   c. _____ SHCC can email me to my email address on record

4. NO SHOW POLICY: Due to the demand for services and limited resources, I understand the following policy.
   a. Scheduled appointments- If I have 3 NO SHOWS in a year (Medical and/or Dental), I will no longer be seen at SHCC as a patient for 1 year.
   b. 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.

5. 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.

6. Telemed Appointment Consent: **Initial the line that applies** (a copy of policy available at the front desk)
   _____I agree to participate in telemed visits with my provider through either video and/or phone calls.
   _____I DO NOT wish to participate in telemed visits with my provider.

7. I have been given an opportunity to ask any 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

OFFICE USE ONLY:
EMR:_____

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?

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