



Scotland Community Health Clinic (SCHC) provides primary care at no cost for its patients. Uninsured adult residents of Scotland County who have been screened and approved for eligibility will be seen by appointment only. SCHC provides chronic disease management for diseases such as high blood pressure, high cholesterol, diabetes and asthma. SCHC provides annual follow-up exams, female wellness, and prescription assistance for certain medications. We assist where possible with imaging, blood work, or tests that are referred from our clinic. *For services received outside the clinic Scotland Community Health Clinic is not a guarantor of payment.*

SCHC **does not provide** secondary or specialty care, dental care, eye care, mental health, or chronic pain management using controlled substance prescriptions.

Operating and support funds come from donations and grants. SCHC does not received appropriated funds through federal, state, or local taxes.

As a patient at the clinic, we ask that you do the following things:

- Notify the clinic immediately if you have or begin receiving insurance, i.e., Medicaid, Medicare or private insurance.
- Keep you appointment. Wait time for an initial appointment can take 2 months depending on provider hours and scheduling. Therefore it's important that you keep your appointment.
- If you have to cancel or change an appointment, please provide *at least 60 minutes advance notice* but preferably 24 hours so SCHC can fill the vacancy. **Failure to cancel in advance will result in a no show fee to be collected prior to scheduling your next visit.** (See our No Show Policy.)
- Bring in all your medications in their most recent bottles to your provider follow up visits (or your appointment may be canceled). Do not bring insulin.
- Please be patient. We understand you may have anxiety or pain. Rudeness or profanity will not be tolerated and may be cause for immediate dismissal from care at this clinic.

Your participation as a patient indicates that you will abide by the clinic's policies and guidelines.

If you are found to be eligible, we look forward to serving you as a patient at our clinic. If you have any questions or concerns during the time you are a patient at this clinic, always feel free to contact me directly.

Sincerely,

A handwritten signature in blue ink that reads "Andrew Kurtzman". The signature is fluid and cursive, written in a professional style.

Andrew Kurtzman
Executive Director

SCOTLAND COMMUNITY HEALTH CLINIC ENROLLMENT CHECKLIST
(Addendum to Application, Updated 6/20/19)

Refer to this checklist as you complete and sign the following documents for your application to be accepted:

Page 1 _____ Application page 1 - Fill in **ALL** information.
If you have questions, ask or call the clinic at 910-276-9912.

Page 2 _____ Application page 2 - – Sign and date your application
ATTACH A COPY OF YOUR NC DRIVER LICENSE OR NC STATE ID WITH THE APPLICATION. If you address on your ID and your current address ARE NOT A MATCH, attach a recent bill addressed to you at correct address, or get your ID updated at the North Carolina License Bureau.

INCOME SOURCES: If you do not have a certain source of income (wages), put 0.

- If you work or your spouse works, attach a copy of **one month's worth of recent check stubs with dates that are back-to-back** to be considered as a patient at this clinic. (4 consecutive check weeks)
- **If you or your spouse files taxes, attach a copy of your Form 1040, 1040A or 1040 EZ tax return.** If you have your own business, please attach a copy of your Schedule C filed with your tax return as well. If you did not file taxes, please fill out Form 4506T on page 7, attached with this application.
- Are you listed as a dependent on anyone else's tax return? ___ Yes ___ No
If YES, attach a copy of their return.
- If you get Social Security, Disability, Retirement or any monthly check, attach **the most current year's copy of your statement** in order to be considered as a patient at this clinic.
- If you do **NOT** have any monthly income at all, please have **the "Food, Shelter and Support Form" signed (included in this packet)** by whoever helps with your day-to-day needs in order to be considered as a patient at this clinic. (See Page 6 instructions).

Page 3 _____ Patient Medical Information Sheet –
Complete all the blanks and check/circle items on this page.

Page 4 _____ Release of Medication Information – please sign and date to allow any other physician to request and receive medical information.
Check the "Yes" box at the top, which indicates your approval to release information.

Page 5 _____ Receipt of Foods Stamps Verification. Do not mark through or write outside the lines provided on this page.
Complete the information above the dotted line. Do not write below the line. This form is sent to Scotland County Social Services for all applicants.

Page 6 _____ If you have NO INCOME (other than Food Stamps), HAVE SOMEONE THAT PROVIDES YOU SUPPORT COMPLETE THIS "FOOD, SHELTER, AND FINANCIAL SUPPORT VERIFICATION FORM." It must be completed by one of the following:

Friend, family member, or significant other that helps you in any way.... for food, shelter, or who pays a bill, etc.

If you receive public housing, attach a copy of your most recent housing contract dated within the past 12 months with either THE LAURINBURG HOUSING AUTHORITY or SECTION 8 HOUSING.

Page 7 _____ 4506-T – Request for Transcript of Tax Return -
This is to verify that you **did not file taxes, whether or not you are working.**

If you **did not file taxes in the current year**, COMPLETE SECTIONS 1a through 4. SIGN, DATE, and put YOUR PHONE NUMBER AT THE BOTTOM.

NOTE: If you are **WORKING AND FILE TAXES, do not sign** this form...
INSTEAD, ATTACH THE FOLLOWING REQUIRED DOCUMENTS:

- YOUR PREVIOUS YEAR TAX RETURN – ONE OR TWO PAGES, whichever you filed (1040, 1040A, or 1040EZ)
- ONE MONTH'S MOST RECENT PAYSTUBS (whether you are paid weekly, bi-weekly or monthly).

Page 8 _____ HIPPA Privacy Rule – sign and date both the original and PATIENT COPY.

Page 9 _____ Please READ THE NO SHOW POLICY – Sign and date original and patient copies to acknowledge you understand you will be charged \$10 if you do not call to cancel at least 60 min. prior to your appointment.

***NEW PATIENTS will be charged \$20 if notification of cancellation is not made at least 60 minutes** PRIOR TO APPOINTMENT.

Page 10 _____ Limited Power of Attorney
Sign and date this form. It allows us to order your free medication without having you come in and sign an application each time we order your meds. This is the **ONLY** purpose we use it for – to sign your name for you on a pharmaceutical patient assistance program form for your meds.

Scotland Community Health Clinic Enrollment Checklist
5/17/18 V.1

Updated 6/20/19 V.2, Located:
Scotland Community Health Clinic Enrollment
Checklist Updated 6-20-19

Eligibility Questionnaire Page 2

Name: _____

Please list your **current monthly household income** (total wages/earnings for all family members) \$ _____

Do you or your family members have any **other sources of income** such as:

(Attach supporting verification for any items checked "yes")

Unemployment	_____ YES	_____ NO	Monthly Amount Received	\$ _____	
Social Security	_____ YES	_____ NO	Monthly Amount Received	\$ _____	
Disability Income	_____ YES	_____ NO	Monthly Amount Received	\$ _____	
Retirement Income	_____ YES	_____ NO	Monthly Amount Received	\$ _____	
WFFA (Work First)	_____ YES	_____ NO	Monthly Amount Received	\$ _____	
Food Stamps	_____ YES	_____ NO	Monthly Amount Received	\$ _____	Verification from DSS needed.
Other	_____ YES	_____ NO	Monthly Amount Received	\$ _____	

TOTAL MONTHLY HOUSEHOLD INCOME \$ _____

Family Size: Number of family living in the same house as you, including yourself: _____. Put "1" if you live alone.
Please list below the names and ages of **all members** of your family, including yourself, that currently live in your household:

Name /Age / Relationship (self)	Name/ Age /Relationship
_____	_____
_____	_____
_____	_____

When all documentation is present, a staff worker will review this document for completeness and it will go to a panel to be checked. Once the determination is made as to your eligibility, you will receive a phone call from the clinic regarding an appointment which may be several weeks away due to the number of existing appointments and provider staff.

Falsifying information will result in denial of care at this clinic

I understand that the answers to the questions above will be used to determine my eligibility for clinic services and that my signature below indicates that I have answered them truthfully and to the best of my knowledge. I understand that if I cannot provide all documentation needed that I will not be eligible for consideration to receive services at this SCHC.

My signature below authorizes Scotland Community Health Clinic to make inquiries and receive information to verify criteria noted above regarding my residency, financial status, and availability of health insurance.

Applicant's Signature: _____ Date: _____

Eligibility Worker's Signature: _____ Date: _____

Patient Eligibility Approved /Denied by: _____ Date: _____

SCOTLAND COMMUNITY HEALTH CLINIC

RELEASE OF MEDICAL INFORMATION

1. I hereby authorize Scotland Community Health Clinic **to request and receive** medical information from the record(s) of all physicians or facilities listed as part of my patient questionnaire or found to be necessary by my provider. Information requested may include information relating to sexually transmitted disease (STD, AIDS, HIV, mental health services of treatment for alcohol and drug abuse. __Yes __No

If no, please list below only the providers from whom we may request necessary information.

Name of physicians/facilities: Name, city, and phone (if known)

2. I hereby authorize Scotland Community Health Clinic **to send** medical information on my behalf to the physicians or facilities deemed necessary by my provider and the following physicians or facilities:

3. I acknowledge that have received a copy of SCHC HIPPA and privacy act policies (included in packet)

Printed Name: _____ **Signature:** _____ **Date:** _____

Please list below others who can access your medical information (do not list physicians).

Name and Relationship:

If you think we have violated your privacy rights you may file a written complaint with the clinic's Executive Director who serves as our privacy officer. You may also send a written complaint to:

The US Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

We will take no retaliatory action against you if you file a complaint about our privacy practices.



Scotland Community Health Clinic
1405-B West Blvd.
P. O. Box 2050
Laurinburg, NC 28353
Phone: 910-276-9912
Fax: 910-276-9913

Receipt of Food Stamps Verification

To: Department of Social Services FNS Division
FAX: 910-277-2402

Re: Verification of Receipt of Food Stamps for:

Name: _____ Birth Date: _____ SSN _____

Address: _____

By my signature below I authorize the Department of Social Services FNS to release information to Scotland Community Health Clinic regarding the amount of food stamps I currently receive per month.

Signed: _____ Date: _____
Signature of person seeking eligibility

Do not write below this line (For Department of Social Services use)

DSS Verification:

Amount per month in Food Stamps: \$ _____

County providing food stamps: _____

Verified by: _____ Phone: _____
DSS Representative

Please FAX information back to 910-276-9913 or the patient may bring the form back.
Thank you.



Health Clinic

Food, Shelter, and Financial Support Verification

Date: _____

I, _____, provide financial support/assistance
Name of person providing support

to help _____ with rooming, boarding, and/or
patient's name
miscellaneous expenses each month. I am not legally responsible for this individual's
bills nor do I buy medications for this individual.

Signature of person providing support: _____

Printed name: _____ Relationship to patient: _____

Address: _____

Phone number: _____

Additional comments: _____

Request for Transcript of Tax Return

- ▶ Do not sign this form unless all applicable lines have been completed.
- ▶ Request may be rejected if the form is incomplete or illegible.
- ▶ For more information about Form 4506-T, visit www.irs.gov/form4506t.

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use Form 4506, Request for Copy of Tax Return. There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return
3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)	
4 Previous address shown on the last return filed if different from line 3 (see instructions)	
5a If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. NC MedAssist, 4428 Taggart Creek Rd, Suite 101, Charlotte, NC, 28208, 704-536-1790	
5b Customer file number (if applicable) (see instructions)	

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 Transcript requested. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶

a Return Transcript , which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days.	<input type="checkbox"/>
b Account Transcript , which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days.	<input type="checkbox"/>
c Record of Account , which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days.	<input type="checkbox"/>

7 Verification of Nonfiling, which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days.

8 Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript. The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days.

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / 31 / 2018 / / / /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.

Signature (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
Title (if line 1a above is a corporation, partnership, estate, or trust)		
Spouse's signature	Date	

Sign Here

Purpose of the Privacy Notice: This notice describes how your medical information may be used and disclosed, and how you can get access to the information if needed. Please review carefully. *A detailed notice of privacy practices is available in the clinic waiting room or ask the receptionist.*

Protected Health Information (PHI)-

Any individually identifiable information about a person's past or present physical or mental health condition, which is created or received by a covered entity, in any form including written oral or electronic.

Covered entity – a health care provider, health care clearinghouse or health plan that conducts specified electronic transactions involving PHI

Business Associate – any external individual or entity who performs a function on behalf of a covered entity that involves the use or disclosure or PHI

Treatment – the provision, coordination or management of care to a patient.

Health Care Operations – activities of covered entities related to operating and managing the entity

Personal Representative – someone who has the legal authority to act on behalf of an individual with respect to the Privacy Rules' requirement.

Workforce – employees, volunteers, trainees and others whose work for a covered entity is under the entity's 'direct control, whether or not they are paid.

Permitted Uses and Disclosures

- * Your confidential healthcare information may be released to other healthcare professionals within SCHC for the purpose of providing you with quality health care.
- * Your confidential information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- * Your confidential information may be released to other healthcare providers in the event you need emergency care.
- * Your confidential information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device.
- * Your confidential information may NOT be released for any other purpose than that which is identified in the SCHC Notice of Privacy Practices. *Please read detailed notice available in the clinic waiting room or ask the receptionist.*
- * For requests other than those listed above, your written authorization is required. You may revoke your permission to release confidential information at any time.
- * You may be contacted by the SCHC to remind you of appointments, healthcare treatment options, or other services that may be of interest to you.
- * You have the right to restrict the use of your confidential information. However, the SCHC may choose to refuse your restriction if it is in conflict of providing you with quality care or in the event of emergency information.
- * You may be contacted by the SCHC for the purposes of raising funds to support the SCHC operations.
- * You have the right to restrict the use of your confidential information. However, the SCHC may choose to refuse your restriction if it is in conflict of providing you with quality care or in the event of an emergency situation.
- * You have the right to review, receive copies of or make amendments to your confidential information.
- * You have the right to request an accounting of disclosures of your confidential information.

You have the right to complain to Scotland Community Health Clinic if you believe your rights to privacy have been violated. If you would like to file a complaint with the SCHC Privacy Officer, please contact:

Executive Director
Scotland Community Health Clinic
1405 B West Blvd
Laurinburg, NC 28352
(910) 276-9912

I consent to the uses and disclosures of my health information as outlined above and in the SCHC Notice of Privacy Practices.

Signature of Patient: _____ Date _____

Purpose of the Privacy Notice: This notice describes how your medical information may be used and disclosed, and how you can get access to the information if needed. Please review carefully. A detailed notice of privacy practices is available in the clinic waiting room or ask the receptionist.

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No Show Policy

Your visit will be considered a NO Show if you fail to show for your appointment and have not called the clinic at least **60 minutes** prior to cancel your appointment so that we may attempt to refill it. Provider and staff time is reserved for your appointment. Please honor your commitment to your health care by showing up on time.

You are responsible for keeping your scheduled appointments and for arriving on time. If you arrive later than 10 minutes after your scheduled appointment, you may be asked to reschedule your appointment in order to accommodate patients that have arrived on time.

New patients: Any cancellation must be received at least **60 minutes** prior to your first appointment. If you are a No Show for your first visit you will be charged \$20 to be received before being scheduled for another appointment. If you fail to reschedule within 2 months your status as a patient will be inactivated.

Established patients: If you fail to notify the clinic at least 60 minutes in advance that you are unable to keep your scheduled appointment you will be charged a \$10.00 no show fee. If the clinic is closed please leave a message on our answering machine. The \$10.00 must be received prior to scheduling your next appointment.

With a 2nd No Show you will be barred from receiving patient services and prescription assistance for 6 months and be charged a \$10 No Show fee.

At the end of 6 months you may have to reapply for eligibility if it has been more than a year since your last visit. If you fail to show without notice for three (3) appointments, your name will be removed from our patient list and you will not be eligible for future care at this clinic.

Your signature below indicates that you understand the above policy.

Patient signature: _____ Date: _____

Policy in effect since June 2014

Policy revised June 2019



No Show Policy - *Patient Copy*

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Policy revised June 2019

Scotland Community Health Clinic
1405-B West Blvd.
Laurinburg, NC 28352
(910) 276-9912

Limited Power of Attorney

I _____, appoint Nancy Stanton or her designee, agents of the Scotland Community Health Clinic Medication Access and Review Program, to be my attorney-in-fact, to sign applications and letters for me for the purpose of obtaining prescription medications for me at low cost or no cost, through pharmaceutical manufacturers' prescription assistance programs. This power of attorney will expire one year from date of signature below.

Patient Signature

Date _____

Prescription Assistance Advocate Signature

Date _____

Witness Signature

Date _____