

# Matthews Free Medical Clinic

113 North Ames Street, Matthews, NC 28105

Office: 704-841-8882

Applicant(s)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

(Please Print)

**Applicants must have NO insurance of any kind**

**Applicants must be younger than 64 years of age**

**Please be sure to include the following information with your application. Bring original & 1 copy of each document. Copies of originals will NOT be made at our office. Failure to bring documentation will delay the application process and treatment.**

\_\_\_\_ Copy of Social Security card (if available) for applicant(s).

\_\_\_\_ Copy of picture identification for applicant(s).

\_\_\_\_ Proof of earned income:

Current Tax return

Two recent consecutive paystubs for applicant(s) or a letter from employer on company letterhead about rate of pay per hour and number of hours *per week* worked for the past month for applicant(s) (if paid in cash).

For Self-Employment income, please list all gross earnings for the last 3 consecutive month(s) and please itemize all work expenses for those same months.

\_\_\_\_ Proof of unearned income, if applicable:

Food Stamps acceptance letter

Child Support for \_\_\_\_\_

Social Security Income for \_\_\_\_\_

Unemployment Benefits for \_\_\_\_\_

Workman's Compensation Benefits for \_\_\_\_\_

Housing Assistance Letter

Letter(s) of Support

\_\_\_\_ Copy of 2 recent consecutive Checking and Savings Account Statement(s)

\_\_\_\_ Copy of all monthly bills

\_\_\_\_ Medicaid denial letter

\_\_\_\_ Letter from employer stating if health insurance is offered for employee and/or family, when open enrollment starts and, if health insurance is taken, when would coverage take effect?

**Please call the clinic for the current screening schedule. You must have ALL paperwork completed prior to your eligibility screening. Your application will then be reviewed and after it is determined that you qualify, you will be contacted to schedule a Doctor appointment.**

**We request a \$10.00 donation for each Doctor visit. Cash only please. If your financial situation is dire please notify the staff. We will not deny services to patients due to financial difficulties.**

**NOTE: We do not see pregnant patients. We do not prescribe narcotics.**

**INSTRUCTIONS AND REQUIREMENTS FOR BECOMING A  
PATIENT OF THE MATTHEWS FREE MEDICAL CLINIC**

1. You cannot have health insurance, Medicaid nor Medicare.
2. You must fill in all sections of the application packet and return the **completed** forms with **PROOF OF INCOME**. Your income must not exceed an amount predetermined by this clinic.
3. You must present a picture ID and, if available, a Social Security card.
4. We reserve the right to determine who will be eligible to become a patient. We also reserve the right to discharge patients who do not honor their appointments and/or comply with clinic policies. Common reasons for patient dismissal:
  - a. Failure to show up for scheduled appointments. We require that patients call 24 hours prior to their appointment to cancel or reschedule. New patients will be dismissed immediately if they fail to show up for their first scheduled appointment.
  - b. Seeking drugs
  - c. The Doctor deems that the patient's needs would be better served elsewhere.

This clinic is a non-profit institution. The Doctors and Nurses are volunteers. The Matthews Free Medical Clinic relies on donations from citizens of the community, local organizations and grants in order to serve our patients. We are not affiliated with any hospital or government agency. Our services are limited to basic health care.

**Matthews Free Medical Clinic will do whatever we can to help, BUT, potential patients are not guaranteed nor entitled to specific services.**

By signing this document you acknowledge that you understand the contents of this document and agree to comply with the Clinic's policies. You also acknowledge that all the information you supply is true. Your information is kept confidential and will not be shared without your permission.

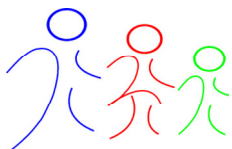
Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient/Authorized representative\*

I understand Matthews Free Medical Clinic operates on a limited availability basis. It is not possible for the volunteer physicians or staff to be available 24 hours a day, seven days a week. Should I ever need emergency medical care, I will dial 911 or go to the nearest emergency room. If I need non-emergency care when the clinic is closed, I will seek alternative health care options such as the local urgent care center.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient/Authorized representative\*

\*If Authorized Representative, please indicate relationship to patient:

\_\_\_ Spouse \_\_\_ Parent \_\_\_ Other (Please specify ) \_\_\_\_\_



Approved

NEW APPLICATION

Denied

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Matthews Free Medical Clinic

\_\_\_\_\_  
Last name First name MI SSN/W-7/Cares ID

\_\_\_\_\_  
NBA ID (Please leave blank) Birth Date: mm/dd/yyyy Age Gender: Male Female Race

\_\_\_\_\_  
Street Address PO Box (mailing only)

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Home Phone Alternate Phone Cell Phone Work Phone

\_\_\_\_\_  
Language Need Interpreter? Yes No

Housing: Own Rent Community Shelter Lived in Mecklenburg or Union Cty. for:  
Staying with Family/Friends Homeless \_\_\_\_\_ yrs \_\_\_\_\_ months

\_\_\_\_\_  
Household Name (Please leave blank) Marital Status: Single Married Divorced Widow(er)  
Separated Civil Union  
Family Size \_\_\_\_\_

Are you a U.S. Citizen? Are you a U.S. resident?

Do you work? Yes No If yes, where? \_\_\_\_\_ For how long? \_\_\_\_\_

If no, where did you last work and when? \_\_\_\_\_

Do you currently have health insurance? Yes No

Have you or anyone listed in this application applied for Medicaid? yes no If yes, who? \_\_\_\_\_

Have you or anyone listed in this application served in the US Military? yes no If yes, who? \_\_\_\_\_

Have you or anyone listed in this application retired from the US Military? yes no

Have you been seen by any Carolina's Medical Center Facility within the last two years, including the Behavioral Health Center? Yes No If yes, when, where and why? \_\_\_\_\_

Emergency Contact Information:

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_  
Name: \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

I certify that the above information is correct and grant the staff at Matthews Free Medical Clinic permission to release pertinent financial records.

SIGNATURE \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient/Authorized Representative

List Family Members (Only spouse and children)								
Last Name	First Name	Relationship	DOB mm/dd/yy	Sex F/M	Marital Status	Race	SS# or W-7	Applying for this person? Yes No
								Yes No
								Yes No
								Yes No
								Yes No
								Yes No
								Yes No

**CREDIT REPORTING AUTHORIZATION**

In determining whether you are eligible, Matthews Free Medical Clinic may need to get a consumer report from a credit-reporting agency. Matthews Free Medical Clinic will only use your consumer report to check your social security number, financial information, work status, and address. Your consumer report will not be shared with anyone who is not working with Matthews Free Medical Clinic.

By signing this document, you give your permission for Matthews Free Medical Clinic or a company hired by Matthews Free Medical Clinic to get one copy of your consumer report from a credit reporting agency before you are selected for Matthews Free Medical Clinic and if you are selected for Matthews Free Medical Clinic, another copy six (6) months later.

*I certify that to the best of my knowledge, all statements are true and correct.*

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Spouse's Signature**

**Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Matthews Free Medical Clinic *(office use only)*

**FINANCIAL CALCULATION**

Number of household members considered in income calculation \_\_\_\_\_

1. Total Income (gross) \$ \_\_\_\_\_ per month

X 12 months \$ \_\_\_\_\_ Annual

**Biweekly** /2x2.15 **Weekly** / #weeks x 4.3 **2 Times per month** / 2 x 2

2. Total Unearned Income \$ \_\_\_\_\_ Per month

X 12 months \$ \_\_\_\_\_ Annual

TOTAL INCOME (1+2) \$ \_\_\_\_\_ Yearly

Notes: \_\_\_\_\_

Processed by \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Volunteers In Medicine

Name: \_\_\_\_\_

## Income &amp; Expense Monthly Review

(For self-employed applicant 3 months, otherwise 1 month)

<b>INCOME (Monthly)</b>	<b>Month of</b>	<b>Month of</b>	<b>Month of</b>
Gross Income	\$	\$	\$
Child support (receiving)	\$	\$	\$
Alimony (receiving)	\$	\$	\$
Family/Friends support	\$	\$	\$
Food Stamps, Disability, SSI, Retirement, HUD, Welfare, Etc.	\$	\$	\$
Rental Property	\$	\$	\$
Other (please explain)	\$	\$	\$
<b>Total Monthly Gross Income</b>	\$	\$	\$
<b>Total Annual Gross Income</b>	\$	\$	\$
<b>BANK INFORMATION (Monthly)</b>			
Personal Account	\$	\$	\$
Deposits: Checking/Money Market	\$	\$	\$
Deposits: Savings	\$	\$	\$
Business Account	\$	\$	\$
Deposits: Checking	\$	\$	\$
<b>Total Deposits</b>	\$	\$	\$
<b>Total Annual Gross Income</b>	\$	\$	\$
<b>EXPENSES (Monthly)</b>			
Rent/Mortgage	\$	\$	\$
Water	\$	\$	\$
Gas/Electricity	\$	\$	\$
Telephone (listed in your name)	\$	\$	\$
Cable/Direct TV/Dish	\$	\$	\$
Internet	\$	\$	\$
Food	\$	\$	\$
Vehicle Payment(s) (monthly)	\$	\$	\$
Vehicle Insurance (monthly)	\$	\$	\$
Gasoline	\$	\$	\$
Medical/Dental Expenses	\$	\$	\$
Tuition/College Loans	\$	\$	\$
Child Support (paying)	\$	\$	\$
Alimony (paying)	\$	\$	\$
Child care	\$	\$	\$
Entertainment/Vacation	\$	\$	\$
Property Taxes (monthly)	\$	\$	\$
House Insurance (monthly)	\$	\$	\$
<b>Total Monthly Expenses</b>	\$	\$	\$

*Please attach copy of supporting documents above****Please attach COPY of documentation of the above***



## Matthews Free Medical Clinic

Volunteers in Medicine

### **LETTER OF SUPPORT\***

Date: \_\_\_\_\_

I, \_\_\_\_\_ (name of person providing support), pay rent and utilities on behalf of  
*or* for \_\_\_\_\_ (person being supported). I am not financially responsible for  
 his/her bills nor able to buy his/her medications. I provide room and board in the amount of  
 \$ \_\_\_\_\_ per month (dollar value of support).

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Relationship to Patient

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Phone Number

**\*IF MORE THAN ONE PERSON IS SUPPORTING YOU, YOU WILL NEED TO GET A LETTER OF SUPPORT FROM EACH ONE.**

**STATEMENT OF NO INCOME:** If you have **no** monthly income please read and sign the following statement.

I, \_\_\_\_\_ do not currently have any income, which includes but is not limited to, wages, unemployment benefits, disability benefits, self-employment income, Social Security and retirement. I understand that it is my responsibility to report to Matthews Free Medical Clinic the start of any income within 10 days of its beginnings. IF YOU HAVE NO INCOME PLEASE TELL US HOW YOUR HOUSEHOLD BILLS ARE PAID. IF ANOTHER PERSON PAYS THE BILLS, PLEASE PROVIDE A SIGNED LETTER(S) OF SUPPORT.

**IT IS VERY IMPORTANT ALL INCOME INFORMATION IS PROVIDED. PROVIDING THIS INFORMATION WILL NOT AUTOMATICALLY DISQUALIFY YOU AS A PATIENT. INCOME GUIDELINES ARE PREDETERMINED BY THIS CLINIC.**

By signing this document I am agreeing that all of the information is accurate to the best of my knowledge.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## MATTHEWS FREE MEDICAL CLINIC HEALTH HISTORY

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
*Print Last First MI*

ADDRESS: \_\_\_\_\_  
*Street apartment City State zip*

PHONE: \_\_\_\_\_  
*Home Work Cell*

WHY WOULD YOU LIKE TO MAKE AN APPOINTMENT WITH THE DOCTOR? (WHAT IS THE PROBLEM)

\_\_\_\_\_

\_\_\_\_\_

<p>List current medications (dose &amp; frequency):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If there are more, list on a separate attached sheet.</p>	<p>List any medications you are allergic to &amp; the reaction you experienced:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List all other allergies:</p> <p>_____</p> <p>_____</p> <p>_____</p>								
<p>List all over the counter or herbal medications that you take on a regular basis:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">List all previous hospitalizations and surgeries</th> <th style="text-align: left; border-bottom: 1px solid black;">Date</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;">_____</td> <td style="border-bottom: 1px solid black;">_____</td> </tr> <tr> <td style="border-bottom: 1px solid black;">_____</td> <td style="border-bottom: 1px solid black;">_____</td> </tr> <tr> <td style="border-bottom: 1px solid black;">_____</td> <td style="border-bottom: 1px solid black;">_____</td> </tr> </tbody> </table>	List all previous hospitalizations and surgeries	Date	_____	_____	_____	_____	_____	_____
List all previous hospitalizations and surgeries	Date								
_____	_____								
_____	_____								
_____	_____								

**Social History \*\* please be honest \*\***

1. Do you smoke? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Previously  
 If yes, how many packs per day \_\_\_\_\_ and for how many years? \_\_\_\_\_.
2. Do you drink alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Previously  
 If yes, how many drinks per day \_\_\_\_\_ and how many drinks per week? \_\_\_\_\_.
3. Do you use street drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Previously  
 If yes, what kind? \_\_\_\_\_ and have you ever shared needles? \_\_\_\_\_ Yes \_\_\_\_\_ No

\*\*\* Please check all that apply to **YOUR** previous or current health \*\*\*

**GENERAL:**

Weight change in the last year  
 Increase by \_\_\_\_\_  
 Decrease by \_\_\_\_\_  
 Accident, injury or illness not listed above:  
 \_\_\_\_\_

Unusual Childhood Illness:  
 \_\_\_\_\_

Recent travel outside the USA:  
 \_\_\_\_\_

**CARDIOVASCULAR:**

Heart attack/angina  
 Chest pain  
 Palpatations/irregularities  
 High blood pressure  
 Heart murmur  
 Rheumatic fever  
 Valve problem  
 Poor circulation  
 Varicose Veins/blood clots  
 Thrombophlebitis  
 Other:

**PULMONARY:**

Unexplained shortness of breath  
 At night?  
 Pneumonia  
 Chronic bronchitis  
 Emphysema  
 Asthma  
 Date of last attack? \_\_\_\_\_  
 Cough  
 Blood/blood tinged cough  
 Sinus condition  
 Hay fever  
 Other:

**ENDOCRINE:**

Diabetes  
 Thyroid condition  
 Cortisone treatment  
 Obesity  
 Other:

**RHEUMATOLOGY:**

Stiff or swollen joints  
 Back Pain  
 Sciatica  
 Bursitis  
 Arthritis, rheumatism, or gout

**INFECTIOUS DISEASE:**

Serious infection  
 What: \_\_\_\_\_

Tuberculosis (or positive skin test)  
 Night sweats  
 Fever  
 Other:

**GASTROINTESTINAL:**

Nausea/vomiting  
 Diarrhea  
 Constipation  
 Recent change in bowels  
 Ulcers  
 When: \_\_\_\_\_  
 Yellow jaundice  
 Hepatitis  
 Gall bladder disease  
 Pancreatitis  
 Heartburn/indigestion  
 GI bleeding  
 Bloody stool  
 Black tarry stools  
 Oily/clay colored stools  
 Hemorrhoids  
 Abdominal pain  
 Bloating/gas pains  
 Hernia  
 Colitis/spastic colon  
 Diverticulitis  
 Other:

**NEUROLOGICAL:**

Headaches:  
 Migraine  
 Tension  
 Sinus  
 Seizure disorder  
 Neuritis/neuralgia  
 Meningitis/polio  
 Stroke  
 Date? \_\_\_\_\_  
 Dizzy spells/blackouts  
 Vertigo  
 Weakness/numbness in extremity  
 Unconsciousness  
 Nervousness  
 Vision problem  
 Date of last exam: \_\_\_\_\_  
 Hearing problem  
 Other:

**MUSCULO-SKELETAL:**

Previous history of fracture  
 Osteopenia or Osteoporosis  
 Joint surgery

**MISCELLANEOUS:**

Depression  
 Recent death of a family/friend

Increased pressure from work, spouse, family  
 Crying spells  
 Insomnia  
 Extreme weakness/tiredness  
 Nervous breakdown/mental illness  
 Changes in skin  
 Other:

**GENITO-URINARY:**

Kidney damage  
 Kidney stone  
 Bladder infection(s)  
 Blood in urine  
 Frequent urination  
 More than 1 urination at night  
 Albumin, pus, protein in urine  
 Venereal disease  
 Discharge from penis  
 Swollen testicle  
 Prostate trouble  
 Other:

**MENSTRUAL HISTORY:**

Onset of menses: \_\_\_\_\_  
 Date of last period: \_\_\_\_\_  
 Length of period: \_\_\_\_\_  
 Number of pregnancies: \_\_\_\_\_  
 No. of miscarriage/abortions: \_\_\_\_\_  
 Pregnancy complications: \_\_\_\_\_  
 \_\_\_\_\_

Menstrual irregularity  
 Severe cramps  
 Mental tension before/during periods  
 Decreased flow  
 Flooding  
 Spotting/discharge  
 Other:

**HEMATOLOGY/ONCOLOGY:**

Bleeding disorder  
 Anemia  
 Easy bruising  
 Enlarged lymph nodes  
 Cancer/tumor  
 Other:

**PREVIOUS TREATMENT:**

Special Diet  
 Blood thinners  
 Tranquilizers  
 Vitamins  
 Frequent laxatives  
 Birth control pills  
 Treatment for alcoholism  
 Treatment for drug use  
 Other:

## FAMILY'S HEALTH HISTORY

CONDITION	YES	BLOOD RELATIVE/ RELATIONSHIP	CONDITION	YES	BLOOD RELATIVE/ RELATIONSHIP
Anemia			High blood pressure		
Arthritis			Thyroid hyper or hypo		
Asthma			Hepatitis		
Bladder Infection			Headaches or migraines		
Blindness			Heart Attack		
Bronchitis			Heart Failure		
Cataracts			Kidney infections or stones		
Cirrhosis of the liver			Seizures		
Diabetes: Non-insulin dependent			Sexually transmitted diseases		
Diabetes: Insulin dependent			Strokes		
Emphysema			Tuberculosis		
Cancer			Ulcers		
Osteoporosis					

Family History: Please write "yes" in the "yes" column if a blood relative has ever been treated for the listed condition and then provide the nature of the relationship. For example: grandfather, uncle, sister, etc.

**Matthews Free Medical Clinic**

Phone: 704-841-8882 Fax: 704-841-8879

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Address: \_\_\_\_\_  
\_\_\_\_\_**Information to be released FROM** *(to get records from your previous health care provider)*

Facility and/or doctor's name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Date of services requested: From \_\_\_\_\_ TO \_\_\_\_\_

Check information to be released (used or disclosed):  Office notes  radiology reports/imaging x-rays  
 Laboratory/pathology reports  EKG/monitors  Other (specify) \_\_\_\_\_Check purpose of disclosure:  medical review  legal review  personal use  other (specify) \_\_\_\_\_**Information to be released TO: MATTHEWS FREE MEDICAL CLINIC**

113 North Ames Street, Matthews, NC 28105

Phone: 704-841-8882 Fax: 704-841-8879

Will the health care provider requesting the authorization receive any financial or in-kind compensation in exchange for using or disclosing the health information described above? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>(office use only)</b>
--

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and /or human immunodeficiency virus (HIV). I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Authorization Representative)

Please note, if information relating to the treatment of drug or alcohol abuse is being released, for a patient under the age of 18, the patient must also sign this **authorization**.

Minor signature \_\_\_\_\_