

# Matthews Health Clinic

113 North Ames Street, Matthews, NC 28105

Office: 704-841-8882

Applicant(s)

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Please Print)

**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?

**Bring your completed paperwork to an Eligibility Screening Clinic, held on the second and fourth Monday of most months between 9:30am and 11:30am. Your packet will be reviewed, and , after it is determined that you qualify, you will be contacted for an 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 HEALTH 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.
  - 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 Health 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 Health 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 Health 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 ) \_\_\_\_\_



Matthews Health Clinic

Approved

NEW APPLICATION

Denied

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

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

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 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 Health 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 Health Clinic may need to get a consumer report from a credit-reporting agency. Matthews Health 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 Health Clinic.

By signing this document, you give your permission for Matthews Health Clinic or a company hired by Matthews Health Clinic to get one copy of your consumer report from a credit reporting agency before you are selected for Matthews Health Clinic and if you are selected for Matthews Health 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 Health 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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## MATTHEWS HEALTH CLINIC

Volunteers In Medicine

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

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 Health 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

\_\_\_\_\_  
 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 Health 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 HEALTH 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
- Palpitations/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:
- MISCELLANEOUS:**
- Depression
- Recent death of 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			Sexually transmitted diseases		
Diabetes: Insulin dependent			Strokes		
Emphysema			Tuberculosis		
Cancer			Ulcers		

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 Health 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 HEALTH 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 \_\_\_\_\_