Main Clinic and Mailing Address
201 W. Boiling Spring Rd.
Southport, NC 28461

(910) 845-5333 F-910-845-5366

website:www.newhopeclinicfree.org

Satellite Clinic/Shallotte
4600-10 Main St.,
Shallotte, NC 28470

email: info@newhopeclinicfree.org

Patient Enrollment Application

Patient Information:

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____/_____/_____ SSN / ITN: _____ Sex: ___ M ___ F ___Transgender

Address: (Street) _____ | (Mailing - if different)_____

(City) _____ (State) ____(Zip)_____ | (City) _____ (State) ____(Zip) _____

Phone: Preferred #: H / C / W (Home) _____(Cell) _____(Work) _____

Race: ____Asian/Pacific Islander ____Am. Indian ____White ____Black/African-American ____More than 1 race

Hispanic/Latino: ___ Y ___ N If yes, check one: ___ Puerto Rican ___ Mexican ___ Cuban ___ Other

Marital Status: ___ Married ___Separated ___Divorced ___Widowed ___Single ___Other

What is your housing arrangement? ___Rent ___Own ___Share expenses ___Homeless ___Other

Primary Language _____ Need Interpretation Services __Y__N

Veteran? _____ Y_____N How did you hear of Cape Fear HealthNet/New Hope Clinic? _____

Do you work? No____ Full time____ Part time____ Self Employed____ Retired____

Are you a student? Y___ N___ If yes, Full time____ Part time____

Tax Information

- Did you file taxes last year? ……___ Y ___ N Did someone else in your house file taxes……__ Y ___ N
  If yes, what is their relationship to you?_____

Insurance/Benefit Information:

- Do you have Medicaid, Medicare, VA Benefits or any other health insurance?…….. ___ Y ___ N
  If yes, what do you have? _____
- Are you eligible for work-based insurance through your employer or your spouse's employer? …… ___ Y ___ N

Medical/Dental Information:

- Where do you go when you are sick? _____
- Give a brief description of your current medical/dental problems: _____

I hereby verify that the information I have given on this application is true and correct. I understand I must provide the information requested to determine my eligibility. WITHOUT ID AND INCOME VERIFICATION, CAPE FEAR HEALTHNET (CFHN) AND NEW HOPE CLINIC (NHC) WILL NOT BE ABLE TO SEND ME FOR OR PROVIDE HEALTH CARE OR MEDICATIONS. I give permission to CFHN or NHC to contact employers and references I have provided to verify information if needed. I understand that providing false information may disqualify me from any present or future assistance with CFHN or NHC. I will report any changes in income, resources and/or family composition within 7 days of change. In the case of ineligibility, I will not reapply for 90 days without extenuating circumstances.

Patient's Signature: _____ **Date**: _____

NHC/CFHN Staff Signature: _____ **Date**: _____

Proof of Identity □ Proof of Residence □ All Proofs of Income □ Tax Return/4506-T □
Monthly Income verified against Federal Poverty Guidelines. □
 # in Household:_____ Gross Monthly Income: $_____ FPL: _____%
Does this applicant qualify for New Hope Clinic services? Yes □ No □ If no, reason: _____
If no, alternatives offered/referred to: _____
Determination made by: (clerk signature)_____ Date:_____

NHC Pt ID_____ AS#_____ NHC DB_____ CFHN_____ NHRMC_____