Main Clinic and Mailing Address
201 W. Bolling Spring Rd.
Southport, NC 28461
P (910) 845-5333 F (910) -845-5366

NEW HOPE CLINIC

Satellite Clinic/Shallotte
4600-10 Main St.,
Shallotte, NC 28470
email: info@newhopeclinicfree.org
website: www.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) _____

Home _____Cell _____Work _____ Phone: Preferred #: H / C / W

Email Address _____

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____

- 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?_____
- Do you have Medicaid, Medicare, VA Benefits or any other health insurance?..... ___ Y ___ N
  If yes, what do you have? _____
- Have you applied for Medicaid? ___Y ___N If yes, submit a copy of the decision letter
- Are you eligible for work-based insurance through your employer or your spouse's employer? ..... ___ Y ___ N
- Where do you go when you are sick? _____
- Give a brief description of your current medical/dental problems: _____
- Is your need for healthcare related to a job-related injury? ____Y ____N
- Is your need for healthcare related to a motor vehicle crash? _____Y ____N

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 and to share this information with auditors, hospitals, or pharmaceutical companies as required. 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:** _____

Interviewed / Policies reviewed by: **NHC/CFHN Staff Signature:** _____ **Date:** _____

Proof of Identity □ Proof of Residence □ All Proofs of Income □ Tax Return/4506-T □

 # 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:_____

2nd Review by Initials _____ Date:_____ Elig File scanned □ PHI form scanned □

NHC Pt ID_____ Athena#_____ NHC DB_____ CFHN_____ NHRMC_____

NOVANT HEALTH

For Office Use Only
Patient Type
Amount of W/O $
S/A Results: h/h $
Facility
Account #
Med. Rec.#

I. Patient Demographics

Patient Name: _____ (Last) (First) (Middle)

_____ (SSN) (DOB)

Guarantor Name: _____ (Last) (First) (Middle) (SSN) (DOB)

Address: _____ (Street) (City) (State) (Zip Code)

_____ (Phone)

Have you applied for Financial Assistance with any Novant Health, Inc. facility (e.g. Novant Medical Group, Presbyterian Hospital, Brunswick Community Hospital, Thomasville Medical Center, Forsyth Medical Center, etc.) in the past?_____ Yes _____ No.
If yes, date of application or approval? _____

II. Household Information

Marital Status (Circle One)	Married	Single	Separated	Total in Household

Dependent Name(s)	Dependent Date of Birth

III. Employment/Income

Patient/Guarantor Employer:
Gross Monthly Income Amount $
Income Source-*Please attach verification or explanation of current situation*
Spouse or other Income Source and Gross Monthly Amount $
Total Annual Gross Household Income $
If no income, how do you support yourself?

Do you have an active bank account?	Did you file taxes for the prior year?

IV. Insurance Verification

Does your employer offer health insurance	YES	NO
Do you have any health insurance	YES	NO
Name of Insurance Company:		
Are you employed?	YES	NO

If you have become unemployed within the last 90 days, please provide:

The name of your last employer and dates of employment:

Give the name of your employer sponsored insurance carrier:

Are you eligible for COBRA Benefits?

I certify that the information provided is true and to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I authorize the release of any information needed to verify the information provided and for billing and collections in compliance with applicable federal and state laws. Proof of income may be required before any consideration is made. Acceptable proof of income maybe but not limited to: copy of paycheck stubs, copy of last year's tax return, or letter from employer stating present salary and hours worked.

Signature Patient/Guarantor:	*Date:*
% Federal Poverty Level:	Decision Based On:
Comments/Summary:	

Signature of Interviewer		Date:		
Signature of Manager		Date:	Approved	Denied
Signature of Director		Date:	Approved	Denied
Signature of EVP/VP		Date:	Approved	Denied

Mail Completed Application to: Novant Health, ATTN: Financial Assistance, PO BOX 11549, Winston Salem, NC 27116

201 W. Boiling Spring Rd.
Southport, NC 28461
www.newhopeclinicfree.org

NEW HOPE CLINIC

Phone: (910) 845-5333
Fax: (910) 845-5366
info@newhopeclinicfree.org

Patient Agreement / Acknowledgement of NHC Handbook & Receipt of Privacy Practices

PATIENT NAME: _____ DATE OF BIRTH: _____

I acknowledge and fully agree to the following matters: (initial by each item)

____ 1. I understand that New Hope Clinic is an independently operated charitable organization that is funded through grants and individual donations. I understand that health care services provided at the New Hope Clinic, Inc. are subject to change due to availability of funding and staff. Services available at New Hope Clinic will be provided free of charge, including visits with our healthcare providers, medications from our limited pharmacy, and tests performed on site. In the event that unavailable services are prescribed, New Hope Clinic will try to arrange for services to be provided a no or reduced cost. I understand that payment for these services is my responsibility and New Hope Clinic is not able to pay for these outside costs. These outside costs may include, but are not limited to, some medications, testing, specialty appointments, and emergency treatment.

____ 2. Good communication between patients and the Clinic is the key to better health & outcomes. New Hope Clinic is committed to providing patients the highest quality healthcare. This can best be accomplished by a clear understanding about the Clinic's responsibilities to patients, and the rights and responsibilities of a Clinic patient. I confirm that I have received the New Hope Clinic, Inc. Patient Handbook dated 10/9/2019 and am responsible for following the guidelines in the handbook. If I do not follow these guidelines, I may be terminated from NHC.

____ 3. **I understand that New Hope Clinic will help me manage my healthcare in many ways, but will not prescribe controlled substances, such as narcotics for pain or benzodiazepines for anxiety, and no controlled substances are kept at the Clinic. I understand that repeated requests for controlled substances will result in dismissal from New Hope Clinic.**

____4. I, (the patient) am ____ years of age and I am either able to read this, or I have had this document read to me by the witness/reader whose name appears below.

Privacy Practices: It is required that we protect the privacy of health information of our patients. You may request that only certain individuals (usually close family or friends) be given information about your health, treatment or other personal information. You can also request how New Hope Clinic communicates information to you. Our clinic participates in the NC Health Information Exchange Authority to share your health information with other medical providers to assist them in making critical medical decisions for you. You have the right to opt out of having your information shared between providers through NC HealthConnex. If you choose to opt out, please ask for the Patient Opt Out Form.

So that we may have a way to contact you or leave a message, please complete the following:

Cell Phone #: _____
Is it OK to leave detailed information on voice mail? Y___ N___
May automated/reminder calls be made to your cell phone? Y____ N ____
May we send you a text messages? Y____ N ____

Home Phone #: _____
It is OK to leave detailed information on voice mail? Y___ N ___
It is OK to leave detailed information with a person? Y___ N___ Name of individual(s):_____

Work Phone #: _____
Is it OK to leave a detailed message on personal voice mail? Y___ N___

Please check which phone number you want us to call first: Home____ Cell ____ Work ____

May automated emails be sent to you? Y___ N____ Email address: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____
Is it OK to leave a message with someone or on voicemail? Y___ N___

If the above are answered NO, a message will be left only stating that our office called and a name and call back number will be left. All correspondence mailed to you will be in a sealed envelope addressed only to you.

I authorize New Hope Clinic, Inc.'s staff to discuss my Protected Health Information with the following individuals:

Name (Please Print)	Relationship to Patient

I acknowledge that I have been given the opportunity to read New Hope Clinic, Inc.'s Notice of Privacy Practices and understand that the above will remain in effect until revised by me.

Date	Time	Patient/Legal Guardian Signature	Printed Name
Date	Time	Reader/Witness Signature	Printed Name

Cape Fear HealthNet
Bridging the Gap for the Uninsured

1601 Doctors Circle
Wilmington, NC 28401
Phone: (910) 399-2751
Fax: (910) 399-2756

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Authorization for Use and Disclosure of Protected Health Information

1.**Disclosure Authorized**. I authorize all of my health care providers, health plans, and case management service providers, and all other persons and entities who have provided, or may be providing me with any type of health care, health insurance or case management services, to disclose all of my protected health information to Cape Fear HealthNet ("CFHN"), and its partners: **Cape Fear Clinic, Good Shepherd Center, MedNorth, New Hope Clinic, New Hanover Regional Medical Center, Black River Family Practice, New Hanover Medical Group, Christ Community Clinic and Coastal Horizons Health with the exception of psychotherapy notes.** I further authorize CFHN and partners to share any protected health care information it obtains from these health care providers, health plans, health insurers and case management service providers to other health care providers, health plans, health insurers, and case management service providers and to all other persons and entities who may be contacted for a health care referral, and to appropriate social service agencies. I authorize CFHN and partners to verify financial information with appropriate service providers and any current or previous employers as is necessary to complete eligibility verification. CFHN staff or partner may also discuss my case with the following persons:

_____ _____ _____
Name Relationship Phone Number

CFHN or partner staff may leave a message on my answering machine/voice mail at home/work or someone else: Y/N
CFHN may communicate with through phone/text/email: Y/N

2. **Purpose of Authorization.** The purpose of this authorization is to enable Cape Fear HealthNet and partners to assist me in managing my medical condition and connect me with other community resources, partners, and medical providers, for services which I might need.
3. **Expiration Date.** This authorization will expire one (1) year from the above date unless revoked by me prior to that date. This authorization may be revoked by me in writing at any time.
4. **Required Disclosures.** I understand that any information used or disclosed under this authorization may be subject to re-disclosure and may no longer be protected under federal privacy rules.

All information provided is true and correct to the best of my knowledge.

_____
Patient Signature **Date**

I certify I will contact/notify the facility in the event I have an insurance and/or income change.

_____
Patient Signature **Date**

I give my consent to release my information to pharmaceutical companies for auditing purposes only in the bulk replacement patient assistance medication programs.

_____
Patient Signature **Date**

I understand that my health care providers and health benefit plans cannot refuse to treat me or deny me benefits simply because I refuse to sign this authorization.

_____
Patient Signature **Print Name** **Date**

_____
Person Signing on Behalf of Patient **Print Name** **Date**

_____
Witness Signature **Print Name** **Date**

to help you as much as we can, however, if you do not recertify in time, your membership will be terminated.

- Be respectful of the CFHN staff, your health care providers and other people when you are at any network provider.
- Know and abide by the rules and regulations of each place you receive services.
- Pay for services that require a co-pay at the time they are received.
- If you are referred to a specialty care provider, the provider will contact you to make the appointment. Please be sure you have voicemail available so they can leave you a message if necessary. The volunteer physicians have agreed to only see patients that are referred through your CFHN primary care provider. If you make and keep an appointment outside of this process, you will be responsible for the bill.
- Contact volunteer physician offices only to reschedule appointments or if the physician asked you to call. All other contact must be through your primary care provider.
- **Please contact CFHN with any questions concerning your enrollment or specialty care referrals.**

Thank you for your commitment to your good health.

Member Signature _____

Date_____

Enrollment Specialist _____

Date_____

Updated: 5/5/20

Cape Fear HealthNet
Bridging the Gap for the Uninsured

Welcome to Cape Fear HealthNet!

It is our goal at Cape Fear HealthNet to facilitate your access to health care.

Cape Fear HealthNet (CFHN) is a system of care for uninsured people with limited income and resources who live in Brunswick, Columbus, New Hanover or Pender Counties. CFHN connects uninsured adults to primary and specialty care providers. CFHN's network of health care providers and organizations are committed to helping you get well and stay well. In many cases, the professionals providing care to you are volunteers. CFHN is not a government program, health insurance or payment source. CFHN cannot guarantee the availability of any service or provider. Programs and services are subject to change. By signing below, you agree to the Member Rights and Responsibilities explained below.

CFHN Members have the right to:

- Receive considerate, respectful and compassionate care by licensed medical professionals, volunteering to serve you, regardless of age, gender, race, national origin, religion, sexual orientation or disabilities.
- Know the cost of care in advance to the extent possible. Some services are donated by volunteers, but you may have a small co-pay for services and/or medication or pay on a sliding scale based on your income. It is your responsibility to understand what your commitment is, ask questions about that commitment and to honor it.
- Expect that all communications and records pertaining to your care will be treated as confidential except as required by law. Medical records are kept confidential per HIPAA regulations. We do collect general information to report to our funders, for example: county of residence and services used.
- Receive complete information regarding your condition, how to manage it, benefits and risks of completing the treatment or not, and expected outcome of the condition after management.
- Participate fully in decisions about your care and treatment and involve family and/or friends you designate to participate in decisions about your care.

CFHN Members have the responsibility to:

- Provide accurate and complete eligibility information and report any changes to CFHN immediately (insurance, pay raise, new job, change in the number of household members, etc).
- Attend all appointments on time. If you must miss an appointment, including appointments with CFHN staff, you must reschedule as required by the individual practice. Failure to provide the required advance notice for a specialty care appointment may result in suspension from CFHN services. Please contact your Enrollment and Eligibility Specialist with any transportation issues before your appointment.
- Present your CFHN membership card and a photo identification card at all health care appointments. Your membership card cannot be used by any other person. This card is not valid if the signature under the seal is tampered with. If a family member or friend needs assistance they should contact CFHN to be screened and if eligible issued their own card.
- Understand that your membership is generally for a full year from enrollment date. However, from time to time, we might issue a shorter-term membership for people likely to receive Medicaid or other services in the near future. Be sure to contact your Enrollment and Eligibility Specialist one month before your membership will end so that you can be recertified. We want