UNINSURED APPLICATION

Fredericksburg Christian Health Center
1129 Heatherstone Drive
Fredericksburg, VA 22407
Phone-540-785-8500 Fax-540-785-5328

To apply please complete this application & bring all documents listed below
Tuesday & Wednesday 9AM-1PM

- € **Photo ID** (Driver's License, DMV issued ID, Passport, or Permanent Resident Card)
- € **Proof of current address**: Driver's License is preferred (bill or bank statement is acceptable)
- € **Current Year Taxes or proof from the IRS that you didn't file taxes**
  To get proof of non-filing, or if you need a copy of your tax return, you'll need to get the information from the IRS office. The address/phone is:
  - IRS Northern Virginia, 7980 Quantum Drive, Vienna, Virginia 22182, 1-703-336-4029
  - IRS Richmond Virginia, 400 N 8th Street, Richmond, Virginia 23219, 1-804-916-8700
- € **2 MONTHS of proof of income**
  (Include all income such as paystubs, disability Benefits, Unemployment, Child Support, Alimony, letter from employer stating income, etc.)
- € **Letter of Support** (If you unemployed or if someone is paying some of your expenses)
- € **Food Stamp notice of action, or card—if you currently receive food stamps**
- € **Uninsured Application** (The attached Application)
- € **New Patient Application for each family member(*Only needed if you are a new patient*)**
- € **Co-Pay expected at time of visit. No Show / No Call will be charged a $50 Fee**

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED. PLEASE BRING ALL REQUIRED DOCUMENTS.
For faster service please bring copies of all your documents

You may apply for the Uninsured Program if you:

- Do not have any other health benefits or insurance (including Medicare & Medicaid).
- Have a **HOUSEHOLD INCOME** less than 200% of the Federal Poverty Guidelines.
- Live in the following counties: Spotsylvania, Stafford, Orange, Fredericksburg City, King George, Caroline, or Westmoreland.

- Where did you receive health services prior to coming here?_____
- How did you hear about Fredericksburg Christian Health Center?_____
- Does employer offer insurance plan?_____

Revised 06/20/2018

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Patient Information

Are you a new patient, or are you rescreening (circle one): New Patient Rescreen

Date: ____ / ____ / ____ **Full Legal Name of Responsible Party:** _____

Date of Birth: ____ / _____ / _____ **SSN:** ____-___-____

Race (circle one): Asian / Black / Native American / White / Hispanic / Other

Marital Status: (circle one) Single Married Separated Divorced Widow **Sex**: M/F

Address: _____

City _____ Zip_____ County_____

Primary Phone (____) ____-_____ Secondary Ph (____) ____-_____ Work Ph (___) ____-_____

Dependent/Household Information

Household Size: A household is considered ONLY those included on your taxes
Household information & Relationship to Patient PLEASE **DO NOT LIST PATIENT,** ***extended family or non-family members***

Name: _____DOB___/___/___SS#___-___-____Relation_____Student? Y/N Medicaid? Y/N

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(Attach extra paper if you need to list more family members)

Emergency Contact Information

Emergency Contact (not living with you): Name_____

Address _____

Phone Number (___) _____ - _____ Relationship to Patient _____

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Employment/Monthly Household Income Information	
Gross Monthly Wages (patient)	$
Gross Monthly Wages (spouse/significant other)	$
Gross Monthly Wages (other /second job)	$
Gross Monthly Wages (supporter)	$
Self-Employment Income. If self-employed, what do you do?_____	$
Social Security Income	$
Retirement/Pension	$
Child Support	$
Alimony or Other Spousal Support	$
Food Stamps Income	$
Other Income (i.e: Unemployment Compensation, Workers Comp)	$
TOTAL INCOME	

Employment History

Self: Where are You Employed?_____
Hours per week:_____ Hourly Rate: _____Start Date:_____ End Date:_____

Other: Where Employed?_____
Hours per week:_____ Hourly Rate: _____Start Date:_____ End Date:_____

Miscellaneous Questions	YES	NO
Are you a full-time Student? If yes, where?		
Are you receiving Workers Compensation? If yes, due to what type of injury?		
Are you receiving Vet Admin Assistance? If yes, disability%-_____		
Are you receiving any assistance from any other community Agency, Church, or Organization? If so, where?		
Do you receive Medicare? If yes, circle one: Part A, Part B, Part C, Part D		
Have you applied for Medicaid? If yes, when?		
Do you receive Plan First from Medicaid?		
Do you have any Medical Insurance? If yes, please list the insurance company.		
Have you applied for the Affordable Care Act Insurance (known as Obama care)?		
Did you report income taxes? If no, does anyone claim you on their taxes? If yes, who? If yes, person claiming you will need to provide 2 months proof of income for supporter.		
Do you receive WIC?		

UNINSURED APPLICATION

Medicare / Medicaid Screening

As a part of the application/eligibility process for the Fredericksburg Christian Health Center's uninsured program, you must be screened for Medicare / Medicaid. Please check any boxes which apply to you.

_____ Age 65 or older

_____ Pregnant

_____ Currently receiving Medicare / Medicare

_____ Blind and currently receiving Social Security benefits

_____ Your children live in your home and currently receive Medicaid

_____ Currently receiving Social Security Disability benefits for a disability

_____ None of the above

Are you a U.S. Citizen Yes_____ No_____

In order to be eligible for Medicaid in Virginia you must meet a covered group.
If you checked any of the above boxes you may be eligible for Medicaid. You must apply for Medicaid if you meet one of the covered groups and provide verification that you have applied in order to be evaluated for the uninsured program here at FCHC. You can apply for Medicaid at your local Social Services agency, online at www.commonhelp.virginia.gov, or by phone at 855-242-8282.

If you need assistance with applying for Medicaid please ask the eligibility screener for further information. If you did not check any of the above boxes then you most likely would not qualify for Medicaid coverage, however, you have the right to apply at any time.

_____ _____
Patient Signature Date

****By signing this form you understand that this form was created in conjunction with the Department of Social Services for the purposes of evaluating your eligibility for services at FCHC. By completing this form you **are not applying for Medicaid** you are only being screened to determine if you meet a Medicaid category to determine eligibility for FCHC's uninsured program. **You may apply for Medicaid at any time** at your local Social Services agency, online at www.commonhelp.virginia.gov, or by phone at 855-242-8282.*

UNINSURED APPLICATION

Letter of Support

This needs to be completed if you aren't working and don't have any source of income, or if you receive financial support from someone.

I, _____, (Supporter's Name)

provide _____ (Patient's Name) with the following services, **Check all that apply**:

- Patient lives with me at my residence in Fredericksburg, Caroline, King George, Spotsylvania, Stafford or Westmoreland County.
- Food
- Housing and Rent
- Financial Support
- Transportation
- I claim the above patient on my taxes **(Please provide us with a copy of last year's tax return)**
- Other: (please specify)_____

If you have NO income:
Why? Example: laid off, injury, Homemaker_____
Have you attempted to apply for Unemployment or disability? Yes/No When?_____
How are you living right now? _____

Name of Supporter _____

Address_____

City, State, Zip _____

Telephone # _____

What is your relationship to the patient? _____ (ie: friend, sister, brother, parent)

Signature of Supporter _____Date_____

UNINSURED APPLICATION

- You must turn in the required information along with the Uninsured Application to FCHC in order for your screening process to begin. Y**ou will not be able to schedule any appointments until you are approved for the program.** If you want to be seen earlier you will be required to pay for the visit (a 20% discount will be given). You will also be given this discount if you don't meet eligibility for the Uninsured program.

- If it is important that you be seen before you can get an appointment, you may go to the Emergency Room. If you go to the Emergency Room you will be responsible for the services rendered there, we encourage you to apply for Mary Washington Hospital's Charity Care program. If you are admitted to Mary Washington Hospital, you will be under the Hospitalist Doctor's care; therefore, the laboratory and radiology services will be under the hospital's Charity Care program. All other doctors' services will not be adjusted, so you may be billed and will be responsible to contact the billing office to discuss your uninsured status.

- ***Patients on the uninsured program will be rescreened every 12 months. You will be required at that time to resubmit <u>all</u> of the information again***.

- The Uninsured Program does not cover Workman's Compensation or Motor Vehicle Claims.

- Our office has a no call/ no show and same day cancellation policy as follows:
  - If you do not show for an appointment or cancel on the same day for your first appointment, you will not be able to make another appointment for 3 months.
  - **When you have three no call/no shows for an appointment or same day cancellations, you will be permanently dismissed from FCHC.**
  - For each appointment you cancel same day or do not show for, you will be charged $50.

- If you have any address or employment status changes, you will need to notify the office within 2 weeks. If there is anything on this application that is found later to be false, you will be dismissed from the uninsured program and will no longer be able to make appointments at Fredericksburg Christian Health Center.

By signing this form you acknowledge that you have read and understand all of the above information and agree to it. You also certify that this information in this application is correct to the best of your knowledge.

Patient Printed Name: _____ Date: _____

Patient or Responsible Party's Signature: _____

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