

Last Name: _____ First Name: _____
 Date of Birth: _____ Sex: (circle one) M F
 Address: _____ City/State Zip: _____
 Phone Daytime: _____ Phone Cell: _____
 Clinic #:

Jeanie Schmidt Free Clinic- Adult Patient Application

Adults are eligible for services through JSFC if they have been diagnosed with high blood pressure or diabetes, have no insurance, live in Herndon, Reston, Chantilly or Centreville, and provide proof of a household income 200% or less of the Federal Poverty Level.

Documents Needed for Enrollment

1. Photo ID of Patient
2. Proof of Address – piece of mail, lease, mortgage, rental agreement
3. Proof of Income of each member of the household- can include
 - a. W-2
 - b. Tax Return
 - c. Pay stubs for 4 pay periods
 - d. Benefits documentation (unemployment, SSI)
4. Any medications patient is currently taking.
5. Medical Records

<u>Family Size</u>	<u>100%</u>	<u>133%</u>	<u>150%</u>	<u>200%</u>
1	10,830	14,404	16,245	21,660
2	14,570	19,378	21,855	29,140
3	18,310	24,352	27,465	36,620
4	22,050	29,326	33,075	44,100
5	25,790	34,301	38,685	51,580
6	29,530	39,275	44,295	59,060
7	33,270	44,249	49,905	66,540
8	37,010	49,223	55,515	74,020



Please bring this completed package and the above attachments to apply for clinic services Monday – Friday 9 a.m. – 4:00 p.m.

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Adult Patient Application

Diabetic?		Employer	
Hypertensive?		Employment Status	
		Education Level	Under 8 th Grade
			9 th – 12 th grade
SS#			High School Graduate
Primary Language			Some College
Marital Status			College Graduate
Head of Household	Yes No	Emergency Contact Name	
		Emergency Contact Phone	
Race/Ethnicity	American Indian	#Adults in House	
	Asian	#Children <19 in Hhld	
	Black/African American	Annual Hhld Income	
	Middle Eastern	Mon. Individual Income	
	White	Unemployed in Household	Y N
	Other	Disabled in Household	Y N
	Unknown	Insurance Programs	
	Hispanic/Latino		Medicaid
Country of Origin			FAMIS
How Long in			Private Insurance
Fairfax County			Other

The Jeanie Schmidt Free Clinic respects your right to privacy. You, as a client, have the right to make certain choices about the uses and disclosures of your health information. Any information you authorize for use and disclosure may be re-disclosed and is no longer protected. You may amend your elections for restrictions by contacting the Clinical Coordinator.

In consideration of the benefit to me arising from the use of an interpreter provided by the JEANIE SCHMIDT FREE CLINIC of Herndon, Virginia, and of the safety and health benefits resulting from such services, I understand and agree as follows: Volunteers are used in providing services of interpretation of various languages to assist the JEANIE SCHMIDT FREE CLINIC and me in understanding certain health and medical matters that are involved in my treatment through the JEANIE SCHMIDT FREE CLINIC. Volunteers give their best efforts, in good faith, to interpret accurately and fully. If, however, an error occurs in the language interpretations undertaken by the Volunteer, despite his or her best efforts, or for the consequences or results of such an error, I release the Volunteer and the Jeanie Schmidt Free Clinic from any responsibility or any liability. I give this release to the Volunteer and the Jeanie Schmidt Free Clinic for myself and for my family members, my heirs, successors, representatives, agents and assigns, freely and willingly, in recognition of the fact that the Volunteer is providing these interpretation services on behalf of the Jeanie Schmidt Free Clinic for no compensation at all, and purely as a volunteer.

I have reviewed the clinic policies and procedures and by my signature indicate my willingness to follow such procedures or risk termination from the clinic.

Patient Signature _____ Date: _____
 Clinic Staff: _____

Last Name: _____ First Name: _____
Date of Birth: _____ Sex: (circle one) M F
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Jeanie Schmidt Free Clinic
13525 Dulles Technology Drive
Herndon, VA 20171
Fax: (703) 435-6752

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release my healthcare information via fax (703-435-6752) or mail to:

Name: Jeanie Schmidt Free Clinic

Address: 13525 Dulles Technology Drive

City: Herndon State: VA Zip Code: 20171

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ **Date Signed:** _____

Last Name: _____ First Name: _____
Date of Birth: _____ Sex: (circle one) M F
Address: _____ City/State Zip: _____
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Jeanie Schmidt Free Clinic
Verification of Shared Residence and/or Support

This form must be completed by the person with whom you SHARE A RESIDENCE or by the person who is HELPING TO SUPPORT YOU AND YOUR FAMILY by giving you food, shelter, and/or money.

Address of Client _____
Street Address and Apartment Number

Town/City, State and Zip Code

How long has the above client lived at this address? _____

Shared Residence

Check here if you share a residence with the above named client.

Support

Check here if you provide ANY TYPE of support to the above named client

Type of support provided (check all that apply):

_____ Food

_____ Shelter

_____ Financial Support (money given directly to the client). How much EACH month? \$ _____

I expect to provide this support until: _____

I claim the above named client as a dependent on my income tax return: Yes No
If yes, please attach a copy of your most recent tax return.

Signature of person completing this form: _____

Phone Number of person completing this form: _____

Relationship of person completing this form to the above named client _____

Address of person completing this form (if different from client): _____

Last Name: _____ First Name: _____
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Permission to Share information about me

I give permission for the Jeanie Schmidt Free Clinic staff to give information by computer and internet about me to NOVA ScriptsCentral to fill the prescriptions from my doctor or nurse. The clinic will share my

- Name
- Address
- Date of Birth and Gender
- Phone number(s)
- Income
- Allergies
- Health problems
- Prescriptions
- Preferred Language for prescriptions

NOVA ScriptsCentral will only discuss my medical information with my clinic staff or me. Because NOVA ScriptsCentral receives some brand-name donated medications that are closely controlled, I understand NOVA ScriptsCentral may have to show my financial qualification information about me to the companies that make the donations to make sure I am qualified. I give permission for NOVA ScriptsCentral to provide my information for review to these medication donation partners. My Rights:

- At any time I can give my clinic a letter asking to see or have a copy of my medical information.
- If I sign this form I give permission to share my information for 10 years unless I ask to no longer share.
- If I don't want my information shared I will still get medical care from the clinic but will not get my medications from NOVA ScriptsCentral.
- No one will sell or receive something for sharing my medical information.
- I have been able to ask questions about how my information will be used and shared.

By signing this form I give permission for my clinic and NOVA ScriptsCentral to use or share my medical information, and to make my financial information available for review by medication donation partners.

Patient Signature

Date

Last Name: _____ First Name: _____
 Date of Birth: _____ Sex: (circle one) M F
 Address: _____ City/State Zip: _____
 Phone Daytime: _____ Phone Cell: _____
 Clinic #: _____

NOVA ScriptsCentral Pharmacy

If under 18 years of age: Parent or Guarantor: _____

Preferred Language: _____ (oral) _____ (written)

Patient Allergies: (if none known, write "none known") _____

Patient Health Conditions: _____

I certify that the client listed above has been found to have income equal to or less than 200% of the Federal Poverty Level, has no other insurance (Medicaid, Veterans, State Pharmacy) for prescription medications, and lives in our agency's service area.

Do you (patient) currently have any form of health insurance? YES NO

Family Composition:	Name:	Age:	Relationship:	Income/yr:

Total number in family unit _____ **Total Household Income for Family:** _____

If you do not have any income, or your income seem to be too little to support you, how do you pay for shelter, food etc.? _____

Attach attestation letter to show non-income support

I certify that the above information was provided to me by the patient/parent above. I have verified the patient's identity.

Signature of Clinic Screener: _____ **Phone:** (703) 481-8160

Name of Clinic Screener (Print): _____ **Date:** _____

I have disclosed my allergies and current medications to the best of my knowledge. I acknowledge signing and receiving a copy of Permission to Share Information. I certify that I have no health insurance or insurance for medications. I certify that the income information given to the clinic is correct. I certify that I will contact NOVA ScriptsCentral and my health care provider with any changes in income or insurance status.

Patient/Parent or Guarantor Signature: _____ **Date:** _____

Print Name of Patient/Parent or Guarantor: _____

For Office Use Only

Medical Record Number # _____ **Qualification Date:** _____

If applicable, SSN, PRC or VA DL: _____ **(only for limited medications)**

Family Size	100%	133%	150%	200%
1	10,830	14,404	16,245	21,660
2	14,570	19,378	21,855	29,140
3	18,310	24,352	27,465	36,620
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Jeanie Schmidt Free Clinic Procedures/ Policies

We are happy to be your partner in improving and caring for your health. Patients will be considered without regard to race, age, religion, national origin, political or union affiliation, marital status, sex or sexual orientation. Please review the following policies regarding the clinic/patient relationship.

Appointments: All visits with a provider are by appointment only. Patients should provide a translator in their appointment if any language other than Spanish or English is the patient's sole language. Please bring your clinic ID , medications, and blood glucose log to all appointments including referrals.

The following are considered cause for termination: 3 no shows to a clinic or specialty care appointment, Abuse of drugs or alcohol, Leaving the service territory for the period the doctor has requested a follow-up appointment. Leaving the country from 3 or more months is grounds for termination.

A \$4 fee is required for medications picked up at the clinic. Patients are responsible for the cost of medications picked up outside of the clinic. Only those patients with current enrollment documents will receive medications and refills. Refills must be requested 10 days in advance.

Each time a patient is referred to an outside physician they must present their clinic I.D. card. Our referral list includes volunteers and donated services and will be made available to our patients as they are available to us. We cannot accommodate every request for a referral within the existing network. If no specialist is available, the Free Clinic will provide contact information for area medical facilities. Patients are responsible for completing financial assistance paperwork required by specialists. Additional charges may occur when seeing a specialist for medications second opinions or other services outside of the agreement for which the patient will responsible. Patients are to ask before receiving services to insure that they are provided free of charge.

Eligibility Renewal is required every 12 months. All changes to household size, income, address, phone number, and insurance coverage status MUST be reported to the Free Clinic Office within 10 days. Failure to report changes could result in a loss of Free Clinic services.

Services not provided by the Free Clinic- Emergency room visits, Second opinions, Prescriptions written by referring physicians or emergency room doctors Physician services provided which are not authorized by the Free Clinic. Physician services outside of the existing network of volunteers, hospital bills.

I request medical/clinic services from the JS Clinic. I authorize the JS Clinic to collect and share with affiliated providers any health care information. I also authorize providers in the JS Clinic to carry out necessary medical procedures after I have received full explanation of the scope of these procedures.

Patient Signature _____

Patient Name

Date

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Jeanie Schmidt Free Clinic- Tuberculosis Risk Assessment

Country of birth: _____ Year arrived in U.S. _____
Have you traveled outside of the U.S. YES NO
Country? _____ When? _____ Length of Visit _____

Prior Tuberculin skin test result: Date of test _____ Positive Negative

Review of symptoms: Please check if you experience any of the following.

Fever Fatigue Chills Night Sweats Loss of Appetite Shortness
of breath

Weight loss: How many pounds? _____ How long ago? _____
 Cough: Since when? _____ Sputum? Yes No Blood in sputum? Yes
 No

Other symptoms: No Yes

Describe _____

None of the above

Previous TB Treatment: NO YES If yes, when were you treated? _____
What medication did you take for TB? _____ How long did you take it? _____

Possible TB exposure:

Have you been in contact with another person who has tuberculosis? YES NO
Have you ever lived in a shelter? YES NO Have you ever been imprisoned?
 YES NO

* If you are determined to be at risk for tuberculosis, you must go to the health department for testing /treatment before you are eligible to become a patient of Jeanie Schmidt Free Clinic.

OFFICE USE ONLY: Date of assessment: _____

Based on the above assessment, this patient IS IS NOT at risk for TB .

Reason this patient is/is not at
risk: _____

Referred to: _____ Medical reviewer signature _____

Patient Signature _____

Patient Name

Date

Last Name: _____ First Name: _____
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ELIGIBILITY HEALTH REVIEW

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

How well do you speak English? Well Not Well Not Well at All Date: _____

WHAT IS YOUR PRIMARY HEALTH CONCERN?

PLEASE TELL US ABOUT YOUR MAJOR PROBLEMS. Please tell us what you consider to be your most significant health problems and the date the problem started

.....

WOULD YOU SAY THAT IN GENERAL YOUR HEALTH IS: EXCELLENT VERY GOOD FAIR POOR

CHRONIC AND CURRENT HEALTH PROBLEMS

CONDITION/PROBLEM	YEAR OF DIAGNOSIS
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

PAST MEDICAL HISTORY

SURGERIES/PROCEDURE <i>(type of surgery)</i>	WHERE/HOSPITAL	YEAR
1.		
2.		
3.		
4.		
HOSPITALIZATIONS <i>(exclude childbirth)</i>	WHERE/HOSPITAL	YEAR
1.		
2.		
3.		
5.		
MEDICATION USE <i>(name of medication dosage)</i>	How often used	YEAR
1.		
2.		
3.		
4.		
5.		