NEW HOPE CLINIC

Providing patient-centered healthcare and wellness services for underserved adults

Charitable Clinic Program

Do you qualify?

- Are you a Brunswick County resident?
- Do you have a household income at or below 300% of the Federal Poverty Level?
- Are you uninsured and ineligible for full Medicaid, Medicare, and VA Benefits?

If all 3 statements apply to you, you may be eligible for New Hope Clinic

Eligibility Documents

Required of all patients:

□ New Hope Clinic and Cape Fear HealthNet Application Packet
□ Photo ID
□ Two (2) Proofs of Residence (dated within 90 days)

Needed depending on your tax, employment, and benefits situation:

□ Last year's Tax Return – Form 1040 and Schedules
□ Form 4506-T (Verification of Non-Filing)
□ One (1) month of recent paystubs
□ Two (2) months of self-employment records
□ Two (2) months of recent bank/CashApp/Venmo statements (all accounts, all pages)
□ Current Social Security or Disability Benefits Letter
□ Current Unemployment Benefits Letter
□ Documents showing any other income
□ Letter of Support (if no income)
□ VA benefits denial (if applicable)
□ Medicaid denial (if applicable)
□ Other: _____

Please drop-off completed applications at the clinic, or send by mail, email, or fax

Eligibility Specialists Available to help

Mondays and Thursdays
9am-4pm
201 W. Boiling Spring Rd,
Southport, NC 28461

Wednesdays
1pm-4pm
520 Mulberry St,
Shallotte, NC 28470

Contact Us

Address: 201 W. Boiling Spring Rd, Southport, NC 28461
Phone: (910) 845-5333
Fax: (910) 845-5366
Email: info@newhopeclinicnc.org
Website: www.newhopeclinicnc.org

201 W. Boiling Spring Rd.
Southport, NC 28461

NEW HOPE CLINIC

email: info@newhopeclinicfree.org
website: www.newhopeclinicfree.org
P (910) 845-5333 F (910) -845-5366

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
- Have you applied for Disability? ___Y ___N
- 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 3/29/2023 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 each of 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 message? 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	NHC 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**

Form **4506-T**
(June 2023)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

► **Do not sign this form unless all applicable lines have been completed.**
► **Request may be rejected if the form is incomplete or illegible.**
► **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ►

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 transcript.

/ /	/ /	/ /	/ /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

► **Signature** (see instructions) Date

► **Title** (if line 1a above is a corporation, partnership, estate, or trust)

► **Spouse's signature** Date