



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: \_\_\_\_\_

### Eligibility Specialists Available to Help

#### Mondays and Thursdays

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

#### Additional Locations

May be available – please call  
910-845-5333 to check

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

### Contact Us

**Address:** 201 W. Boiling Spring Rd,  
Southport, NC 28461

**Phone:** (910) 845-5333

**Fax:** (910) 845-5366

**Email:** [info@newhopeclinicnc.org](mailto:info@newhopeclinicnc.org)

**Website:** [www.newhopeclinicnc.org](http://www.newhopeclinicnc.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

• 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: \_\_\_\_\_ 1 year  90-day

2<sup>nd</sup> Review by Initials \_\_\_\_\_ Date: \_\_\_\_\_ Elig File scanned  PHI form scanned



## 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 at 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 #: \_\_\_\_\_  
Is it OK to leave detailed information on voice mail? Y\_\_\_ N\_\_\_  
Is it 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 _____
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

## Welcome to Cape Fear HealthNet!

It is our goal at Cape Fear HealthNet to help you access health care.

Welcome to Cape Fear HealthNet (CFHN). Now that you are enrolled, your first step is to contact the primary care provider you chose, \_\_\_\_\_ at \_\_\_\_\_ and make an appointment. **Always bring your CFHN membership card with you to your appointments, including appointments at a Novant Health provider or specialty care provider.** CFHN does not pay medical bills and cannot guarantee the availability of any service or provider. Programs and services are subject to change. Below are helpful reminders and your rights and responsibilities.

### Novant Health Charity Care Program:

- The Charity Care program covers approved, medically necessary hospital services. This program does not cover some hospital doctors/providers who provide care to you during your visit, such as **ER Doctors, Radiologists, Surgeons, Rehabilitation doctors, Anesthesiologists, Pathologists, etc.** **You will receive a separate bill from these providers and are responsible for these bills.** If you receive a bill from Novant NHRMC or one of their providers, please contact their Patient Financial Services office at (910) 667-7050 with any questions. For Novant Brunswick and their providers, please call (910) 721-1404.

### Specialty Care Referrals:

- If your primary care provider determines you need a specialty care provider, your primary care provider must make the referral to the CFHN Specialty Care Coordinator. Our Coordinator will send the referral to the specialty provider, and they will contact you to make the initial appointment. This process can take up to 30 days, so please be patient. Contact your primary care provider if you have questions or concerns. Only contact the specialty care provider to reschedule appointments or if the provider asked you to call. All other contact must be through your primary care provider. **If you make an appointment with a specialist outside of our network and referral process, you will be responsible for that bill.**

### CFHN Members have the right to:

- Receive considerate, respectful, and compassionate care by CFHN and the licensed healthcare 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 to pay on a sliding scale based on your income or a small co-pay for services, medication and/or procedures.
- Expect that all communications and records about your care will be treated as confidential 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 that you choose to participate in decisions about your care.

**CFHN Members have the responsibility to:**

- Supply 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).
- Be on time for all appointments. If you need to reschedule an appointment, including appointments with CFHN staff, you must reschedule as required by the individual practice. Failure to no show for a specialty care appointment may result in a suspension from CFHN services. Please contact your Enrollment and Eligibility Specialist with any transportation issues before your appointment.
- Understand that your membership is for a full year from the enrollment date. However, from time to time, we might issue a shorter-term membership for people likely to receive Medicaid or other coverage soon. Be sure to contact your Enrollment and Eligibility Specialist one month before your membership ends so that you can be re-enrolled. We want to help you as much as we can, however, if you do not re-enroll 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.

.....

Thank you for your commitment to your good health.

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, Novant Health/New Hanover Regional Medical Center, Black River Family Practice, New Hanover Medical Group, Michael Jordan Clinics(Greenfield and East)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
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CFHN or partner staff may leave a message on my 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.

**5. Consent/Certification:**

**I certify all information provided is true and correct to the best of my knowledge.**

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

**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	_____ Print Name	_____ Date
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_____ Person Signing on Behalf of Patient	_____ Print Name	_____ Date
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_____ Witness Signature	_____ Print Name	_____ Date
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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Date of Birth (DOB): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

### Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
<b>Food</b>		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
<b>Housing/ Utilities</b>		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
<b>Transportation</b>		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
<b>Interpersonal Safety</b>		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
<b>Optional: Immediate Need</b>		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

**Internal Office Use**

<b>Type of Visit (select one):</b> <input type="checkbox"/> New Patient <input type="checkbox"/> Annual	<b>Athena ID #:</b> _____	<b>Resources Discussed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<b>Staff Initials:</b> _____	<input type="checkbox"/> Electronic Data Entry <input type="checkbox"/> Scanned to Athena
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**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](http://www.irs.gov/form4506t).**

OMB No. 1545-1872

**Tip: Get faster service:** Online at [www.irs.gov](http://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).

<b>1a</b> Name shown on tax return. If a joint return, enter the name shown first.	<b>1b</b> First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
<b>2a</b> If a joint return, enter spouse's name shown on tax return.	<b>2b</b> Second social security number or individual taxpayer identification number if joint tax return
<b>3</b> Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)	
<b>4</b> Previous address shown on the last return filed if different from line 3 (see instructions)	
<b>5</b> 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.

<b>Signature</b> (see instructions)	Date
<b>Title</b> (if line 1a above is a corporation, partnership, estate, or trust)	
<b>Spouse's signature</b>	Date

**Sign Here**