Greater Bluffton
Jasper County
VOLUNTEERS IN MEDICINE

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PATIENT INFORMATION

This clinic provides free medical care for patients who meet our eligibility requirements. Please review the following information to understand how the clinic works.

Eligibility

- You must live or work in either Greater Bluffton or Jasper County.
  Usted debe vivir o trabajar en Bluffton o en el Condado de Jasper.
- You must have NO health insurance/NO Veterans benefits/NO Medicare/ NO Medicaid.
  Usted no debe tener seguro de salud/ningún beneficio para veteranos/no Medicare/no Medicaid
- You must have income that is equal to or below 250% of the Federal Poverty Level.
  Usted debe tener ingresos iguales o inferiores al 250% del nivel federal de pobreza.

Process and Documents Required

- Complete ALL application forms including consent forms.
  Complete todos los formularios de solicitud incluyendo los formularios de consentimiento.
- Schedule a screening appointment.
  Programe una cita de selección.
- Bring in all paperwork to the screening appointment. No screening or medical appointment will be given until application is complete.
  Traiga todo el papeleo a la cita de selección. No se dará ninguna cita médica hasta que se complete la solicitud.

PHOTO ID- driver's license or passport
ID con foto - *Licencia de conducir o pasaporte*

PROOF OF ADDRESS OF WHERE YOU LIVE OR WORK- such as electric bill, phone bill, driver's license, etc. or a letter from your employer, pay stub with employer's address, etc.
Comprobante de domicilio o de dónde viva o trabaje - *como una factura de electricidad, teléfono, licencia de conducir etc. o una carta del empleador, talón de pago con la dirección del empleador.*

PROOF OF ALL SOURCES OF INCOME- TWO most recent consecutive stubs are required or letter from employer. If you are married you are required to provide the same for your Spouse. Please be advised in the event you are referred in the future to organizations such as Access Health through Beaufort Memorial Hospital you will be required to provide more financial documentation such as bank account statements.
Comprobante de los ingresos de todo tipo - *DOS talones de cheques consecutivos o carta del empleador. Si usted está casado se requiere proveer los mismos para esposo/a. Sea aconsejado que para eventos en el futuro podrá ser referido a otras organizaciones como Access Health a través del Hospital Memorial Beaufort será requisito proveer más documentos financieros como cuentas bancarias.*

- After the eligibility requirements above have been met you will then be scheduled for a doctor's appointment.

Example of the 2019 FEDERAL POVERTY LEVEL

SIZE OF TOTAL HOUSEHOLD	MAXIMUM INCOME LEVEL
1	$30,350
2	$41,150
4	$62,750

BLUFFTON JASPER VOLUNTEERS IN MEDICINE
APPLICATION FOR MEDICAL
(SOLICITUD DE SERVICIOS DE MEDICINA)

Please print (por favor escribe en letras de molde)

DATE *(Fecha)*_____ **EMPLOYER** *(empleador)*_____

PATIENT'S NAME *(nombre del paciente)*		
LAST *(apellido)*	**FIRST** *(nombre)*	**MI** *(inicial)*

ADDRESS *(direccion)*	**CITY** *(cludad)*	**ZIP** *(codigo postal)*

COUNTY *(condado)*	**TELEPHONE NUMBER** *(telefono)*	**SOCIAL SECURITY NUMBER** *(Numero de Seguridad Social)*

DATE OF BIRTH *(fesha de nacimi ento)*	**SEX: M or F** *(sexo) Masculino Femenino*	**MARRIED** (Casado)	**SINGLE** (Soltero)	**OTHER** (Otro)

RACE: *(Raza)* **CIRCLE**				
AFRICAN AMERICAN	**CAUCASIAN**	**HISPANIC**	**ASIAN**	**OTHER**

EMERGENCY CONTACT *(contacto de emergencia)*	**TELEPHONE NUMBER** *(telefono)*	**RELATIONSHIP** *(relacion)*

Full name(s) of all family members (spouse and children under 18) who live with you in your house. *(Nombres completes de todos los miembros de familia (esposo & ninos menores de edad 18) que viven con usted en su casa)*		
FIRST LAST NAME *(Apellido Nombre)*	**RELATIONSHIP** *(Parentesco)*	**DATE OF BIRTH** *(Fecha de Nacimiento)*

PATIENT'S FINANICIAL INFORMATION

PATIENT'S NAME *(nombre del paciente)*

SOURCES OF HOUSEHOLD INCOME *(fuentre de ingresos de la cabeza de familia)*	**GROSS DOCUMENTED CURRENT INCOME AMOUNT** *(Ingresos brutos documentados)*	**NUMBER OF PAYMENTS PER YEAR** *(Numero de pagps por ano)*	**ANNUAL GROSS INCOME** *(Ingreso bruto annual)*
EARNED INCOME (FOR PATIENT) *Ingreso obtenido (para el paciente)*	$		$
EARNED INCOME (FOR SPOUSE IF MARRIED) *Ingreso obtenido (para el conyuge si es casado)*	$		$
SELF-EMPLOYED/BUSINESS INCOME *(Empleado Independiente/Ingresos del negocio)*	$		$
PENSION/RETIRMENT INCOME *(Ingresos Pension/Retiro)*	$		$
UNEMPLOYMENT *(Ingresos Desempleo/Incapacidad)*	$		$
DISABILITY INCOME (SSD/SSI)	$		$
PUBLIC ASSISTANCE (TANF, SNAP) *(Asistencio Publica)*	$		$
ALIMONY, CHILD SUPPORT AND FOSTER CARE INCOME *(Pension alimentica para hijos/adaptados)*	$		$
OTHER (SPECIFY) *(Otros Ingresos/Explique)*	$		$
TOTAL ANNUAL GROSS INCOME FROM ALL SOURCES Ingresos totals (ingreso obtenido por adulto que viven en la casa)		$	

DO YOU HAVE INSURANCE? (CIRCLE) **YES** *(si)* **NO** *(no)*
(Tiene seguro medico?)

If <u>YES</u> what medical coverage do you have? (CIRCLE)

MEDICAID **MEDICARE** **VA BENEFITS** **PRIVATE HEALTH INSURANCE** **OTHER**

Please be advised in the event you should need to be referred to other organizations for continued services you will be <u>required</u> to provide other financial documentation such as bank account statements or you will not be allowed to receive their services.

Patient signature/firma: _____

Date: _____

PATIENT CONSENT FORM

I, _____, consent to receive medical, dental or other services and treatment by the healthcare professional who has voluntarily agreed to provide treatment without compensation or expectation or promise of compensation as provided under section 33-35-210 of the Code of Laws of South Carolina.
Yo, _____, acepto recibir tratamiento medico, dental asi como otros servicios y tratamientos brindados por un profecional de salud un voluntario que ha accedido a proveer el tratamiento sin una compensacion, remuneracion o promesa como se especifica en la seccion 33-35-210 de el codigo de leyes de Carolina del Sur.

Services at Bluffton-Jasper Volunteers in Medicine are offered at no charge. Please note: There may be other expenses which may include, but not limited to, outside referral fees and medications that will be your responsibility.
Los servicios en La Clinica del Condado Bluffton-Jasper Voluntarios en Medicina se ofrecen sin costo alguno. Por favor recuerde: que existen otros gastos, que pueden ser incluidos pero no son limitados, como ser referido a otros lugares y medicinas que correran por su cuenta.

I understand and agree that my provider is not liable for any injury, death, or other loss arising out of giving me these health care services unless injury, death or other loss is caused by my provider's gross negligence.
Yo entiendo y acepto que mi proveedor de salud no es resposable por ningun dano, muerte, o perdida resultante de los servicios de salud recibidos a menos que el dano, perdida o muerte sea causa de negligencia de mi proveedor de salud.

The Volunteers in Medicine Clinic gave me this notice and I signed it before receiving any health care services.
La Clinica de Voluntarios en Medicina me ha dado esta forma y yo la he firmando antes de recibir los servicios de cuidado de salud.

Patient's Name (Print Name in full): *Nombre del Paciente (Completo):*	**Date:** *fecha:*
Patient's Signature: *Firma del Paciente:*	
Patient's Authorized Representative:	**Legal Relationship of Patient:**

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION (OPTIONAL) *Autorización para discutir la información médica*

Information to be given to:

NAME: _____

RELATIONSHIP: _____ **PHONE NUMBER:** _____

Description of the specific information to be discussed:
_____ appointment date/time _____ diagnosis _____ x-ray results _____ medications _____ lab text/results _____ summary of medical record _____ care plan _____ all

This authorization shall remain in effect from the date signed below until (please check one):
_____ NO EXPIRATION DATE
_____ SPECIFY EXPIRATION DATE _____

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Patient Notice of Limited Liability for FTCA Deemed Free Clinic Volunteer Health Care Professionals, Board members, Officers, Employees and Independent Contractors

Notice to Patients

To be provided to the individual patient before health care services provided, except in emergency cases when notice may be provided as soon as the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her case under State Law.

Esta notificacion debe ser entregada al paciente en forma individual antes de ser atendido por los servicios de salud, except en casos de emergencia. Si es atentido en casos de emergencia la notificacion debera proporcionarse immediatemente despues que haya sido atendido o a los padres guardians en caso de que el paciente carezca de resposabilidad propia segun la ley de estado.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA) (See 28 U.S.C sections 1346(b), 2671-80) provides exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental or related functions by any free clinic volunteer health care practitioner, board member, officer, employee or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. The FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board member, officer, employee or independent contractor who has provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic site or through offsite programs or events carried out by the free clinic (see 42 U.S.C. sections 233 (a), (o).

Esto es para noficarle que bajo la ley federal relacionada con la operacion de clinicias voluntarias, la ley de casos federales agraviados(FTC), (2ver 28 U.S.C. 1346 (b). 2401 (b), 2671-80) prove la exclusividad de poder arreglar los danos causados a personas involucradas incluyendo muertes que hayan sido resultado de una practica medica, quirurgica, dental, o cualqier otra cosa practicada por la clinica de voluntaries en la pactica del cuidado de la salud por miembros directivos,oficiales, empleados o contratistas independientes del departamento de salud y servicios humanos que han proporcionado servicios de salud al public. Esta FTCA cobertura medica de salud aplica para dar servicios gratis en la clinica voluntaria ofrecidos por los miembros directivos, oficiales, empleados o contratistas independientes que han proveido un servicio requerido o autorizado bajo el titulo XIX del seguro social act (i.e., Programa medico) a la clinica voluntaria gratuita o por medio de programas fuera de esta clinica voluntaria (ver 42 U.S.C 233 (a). (o).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

La antes mencionada ley federal y otras leyes federales del estado incluyendo la ley federal protectora de los voluntaries act de 1997 puede cubrir ciertas clinicas gratuitas y a los profesionales proveedores del cuidado de salud y servicios a los pacientes de esta clinica.

Patient Name (Print Name in full): *Nombre del Paciente (complete):*	**Date:** *Fecha*
Patient's Signature: *Firma del Paciente:*	
Patient's Authorized Representative:	**Legal Relationship of Patient:**

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
Nuestro Aviso de las Practicas de Confidencialidad proporciona informacion sobre como podemos utilizer y divulger los datos confidenciales de su salud. El aviso contiene una seccion de Derechos del Paciente que describe sus derechos de acuerdo a la ley. Usted tiene el derecho de tomar conocimiento del contenido de nuestro Aviso antes de firmar este consentimiento. Los terminus de nuestro Aviso pueden cambiar. Si cambiamos nuestro Aviso, useted puede obtener una copia actualizada contactandose con nuestra oficina.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
Usted tiene el derecho de solicitor que restrinjamos el uso o divugacion de los datos confidenciales de su salud para ser usados para el tratamiento, pago o operaciones de cuidado medico. No se nos require convener esta restriccion, pero si lo hacemos, lo haremos honrando este acuerdo.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
Al Firmar este acuerdo usted consiente a nuestro uso y divulgacion de los datos confidenciales de su salud para ser usados para el tratamiento, pago o operaciones de cuidado medico. Usted tiene el derecho de revocar esta consentimiento por escrito, firmado por usted. Sin embargo, tal revocacion no afectara ningun uso o divulgacion que hayamos hecho con anterioridad a la revocacion, basados en su authorizacion previa. La Clinica proporciona este formulario a fines de cumplir con el Acta de Transferibilidad y Responsabilidad del Seguro Medico de 1996 (HIPAA).

The patient understands that: *El paciente entiende que:*

- **Protected health information may be disclosed or used for treatment, payment or health care operations**. *Los datos confidenciales de su salud pueden ser divulgados o utilizados para el tratamiento, pago, o operaciones de cuidado medico.*
- **The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice**. *La Clinica tiene un Aviso de las Practicas de Confidencialidad y el paciente tiene oportunidad de informarse sobre dicho Aviso.*
- **The Practice reserves the right to change the Notice of Privacy Practices.** *La Clinica se reserve el derecho de cambiar el Aviso de las Practicas de Confidencialidad.*
- **The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.** *El paciente tiene el derecho de restringir el uso de su datos confidenciales pero La Clinica no tiene obligacion de consenter las restricciones.*
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease.** *El paciente puede revocar este consentimiento por escrito en cualquier momento y cesara toda devulgacion future.*
- **The Practice may condition receipt of treatment upon the execution of this consent.** *La Clinic puede condicionar el suministro de tratamiento a la firma de consentimiento.*

THE CONSENT WAS SIGNED BY:

Patient's printed name/ Letra imprenta- Paciente Date/Fecha

WITNESS:

Printed Name- Practice Representative Date

CLINIC RULES

to be signed at the time of screening

	Patient's Initials	Screener's Initials
1. **All medications will be brought to all appointments.** *Todos los medicamentos se llevarán a todas las citas.*		
2. **Patient is responsible for confirming or cancelling appointments 24 hours prior to appointment.** *El paciente es responsable de confirmar o cancelar citas 24 horas antes de la cita.*		
3. **Clinic may reschedule appointments if patient is more than 20 minutes late or hasn't confirmed an appointment.** *La clínica puede reprogramar citas si el paciente tiene más de 20 minutos de retraso o no ha confirmado una cita.*		
4. **If you miss 3 scheduled appointments without calling to cancel (no show) within a 12 month period, you will <u>not</u> be able to receive services from BJVIM for 6 months.** *Si no te presentas a 3 de su citas, sin hablar para cancelar la cita. No va poder recibir servicios de BJVIM por un periodo de 6 meses.*		
5. **Patient will inform BJVIM promptly if insurance is obtained (Medicare, Commercial Insurance, VA benefits, etc).** *El paciente informará BJVIM puntualmente si se obtiene un seguro.*		
6. **Abusive behavior, physical or oral, may result in permanent dismissal from the clinic.** *Comportamiento abusivo, físico u oral, puede resultar en despido permanente de la clínica.*		
7. **Prescription refills require 24-48 hour notice to fill.** *Las renovaciones de recetas requieren un aviso de 24 a 48 horas para completar.*		
8. **No food is permitted in the clinic waiting area.** *No se permiten alimentos en el área de espera de la clínica.*		
10. **Cell Phones need to remain on silent mode while in the clinic.** *Los teléfonos celulares deben permanecer en modo silencioso mientras se encuentran en la clínica.*		

I have read and understand the above information and consent to comply with eligibility requirements and rules.

Patient's Name (printed): _____ Date: _____

Patient's Signature: _____

1/26/16

Greater Bluffton Jasper County
VOLUNTEERS IN MEDICINE

Employment and Income Verification Form

Self-Employed (If you are self-employed, please complete this section.)

Name (Please Print): _____

Type of Work (Check all that apply)

__ Housekeeping/Cleaning
__ Day Laborer
__ Other (Describe):_____

Gross Pay: $_____ (circle one: weekly/bi-weekly/monthly)
If hourly, how many hours per week:_____

Signature: _____ Date:_____

Employer (To be completed by employer)

The person below has requested health services from our medical clinic. To assist us in financially screening him/her for eligibility to become our patient, would you please verify his/her employment and pay with you. By signing below you also are confirming that this employee does not have health insurance through his/her employer.

Employee's Name (Please Print): _____

Gross Pay: $_____ (circle one: weekly/bi-weekly/monthly)
If hourly, how many hours per week:_____

Company Name : _____

Company Address : _____
_____

Employer's Phone Number:_____
Employer's Signature: _____ Date:_____

1/18/16

Greater Bluffton Jasper County VOLUNTEERS IN MEDICINE

Address Verification Form

Patient Information

Patient Name (Please Print): _____

Phone Number: _____

Person Providing Place to Live for the Patient

Name (Please Print): _____

Phone Number: _____

Relationship to Patient(Please check):

_____ Spouse
_____ Parent
_____ Child
_____ Sibling
_____ Other Family
_____ Friend
_____ Other (Please describe):_____

I attest that I currently provide a place to live for this person at the following address:

Number and Street: _____

Town: _____ Zip Code:_____

County: _____

Signature: _____ Date:_____

*** For Patient Who Is Homeless

I attest that I am currently homeless and living in the Town of Bluffton or in Jasper County.

Patient Signature: _____ Date:_____

1/26/16

Greater Bluffton Jasper County
VOLUNTEERS IN MEDICINE

No Household Income Verification Form

Patient Information

I confirm that I and no one in my household have any income. If I or anyone in my household receives Food Stamps or help from the Housing Authority (HUD), I have attached proof of the amounts from each.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Patient Physical Address:

Street and Number: _____

City: _____

State: _____ Zip Code: _____

Individual Providing Money/Support to the Patient (must be completed)

Name of person providing money/support (Please Print): _____

Phone Number: _____

Money or support provided each month:

$ _____ Housing/Rent (If answer is $0, state why):_____

$ _____ Food (If answer is $0, state why):_____

$ _____ Utilities (If answer is $0, state why):_____

$ _____ Total amount per month provided to patient

Check one: ____ I verify that all informaton provided is accurate and no work or services are given or expected in return for this support, **or**

____ I verify that all information is accurate **and** that the patient performs household chores and/or odd jobs in exchange for the money or support reported provided.

I also verify that to the best of my knowledge the patient lives at the above address.

Signature of person providing support: _____ Date:_____

NOTE: The patient must sign this statement
The person providing support must sign this statement
The patient must attach proofs of amounts received from Food Stamps and/or the Housing Authority (HUD)
The completed form must accompany the Welvista application (may attach multile forms)