MANHATTAN FREE CLINIC

FLINT HILLS COMMUNITY CLINIC INC.

ANNUAL ELIGIBILITY UPDATE FORM

First: _____ Middle: _____ Last: _____

DOB: ___ / ___ / ___ SSN: _____

Address: _____ City: _____ State: _____ Country: _____

County: _____ If not residing in Riley County, reason for service: _____

Home and / Cell Phone: _____ Work Phone: _____ Ext: ____

Email: _____

Emergency Contact: _____ Phone: _____

Relation: _____ Do we have authorization to release information: Yes ☐ No ☐

Is Patient covered by:

- ☐ Insurance
- ☐ Medicaid
- ☐ Medicare
- ☐ Other

Paperwork(s) provided:

- ☐ Photo ID
- ☐ Proof of Income
- ☐ Proof of address

Proof of Income can come in the form of two or three consecutive paystubs, letter from employer/ person or organization who's aiding in financial needs and or housing, 1040 form from tax paperwork.

Patient Signature _____ Date _____

HOUSEHOLD INCOME INFORMATION:

Total number of household: _____ Number of children: _____

Below list the people that provide income within the household **including the Patient**. FHCC requires proof of income from each individual listed within the household.

1. First: _____ Middle: _____ Last: _____

   DOB: ___ / ___ / ___ Sex: M / F Relation: _____

Race:

- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Employment:

- ☐ Disabled
- ☐ Employed- Part-time
- ☐ Employed- Full-time
- ☐ Minor
- ☐ Retired
- ☐ Unemployed

Monthly Income

Salary/Wages: _____

Child Support: _____

Unemployment: _____

Disability: _____

Social Security: _____

Other: _____

Total Income: _____

2. First: _____ Middle: _____ Last: _____

   DOB: ___ / ___ / ___ Sex: M / F Relation: _____

Race:

- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Employment:

- ☐ Disabled
- ☐ Employed- Part-time
- ☐ Employed- Full-time
- ☐ Minor
- ☐ Retired
- ☐ Unemployed

Monthly Income

Salary/Wages: _____

Child Support: _____

Unemployment: _____

Disability: _____

Social Security: _____

Other: _____

Total Income: _____

3. First: _____ Middle: _____ Last: _____

DOB: ___ / ___ / ___ Sex: M / F Relation: _____

Race:

- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Employment:

- ☐ Disabled
- ☐ Employed- Part-time
- ☐ Employed- Full-time
- ☐ Minor
- ☐ Retired
- ☐ Unemployed

Monthly Income

Salary/Wages: _____

Child Support: _____

Unemployment: _____

Disability: _____

Social Security: _____

Other: _____

Total Income: _____

4. First: _____ Middle: _____ Last: _____

DOB: ___ / ___ / ___ Sex: M / F Relation: _____

Race:

- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Employment:

- ☐ Disabled
- ☐ Employed- Part-time
- ☐ Employed- Full-time
- ☐ Minor
- ☐ Retired
- ☐ Unemployed

Monthly Income

Salary/Wages: _____

Child Support: _____

Unemployment: _____

Disability: _____

Social Security: _____

Other: _____

Total Income: _____

5. First: _____ Middle: _____ Last: _____

DOB: ___ / ___ / ___ Sex: M / F Relation: _____

Race:

- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Employment:

- ☐ Disabled
- ☐ Employed- Part-time
- ☐ Employed- Full-time
- ☐ Minor
- ☐ Retired
- ☐ Unemployed

Monthly Income

Salary/Wages: _____

Child Support: _____

Unemployment: _____

Disability: _____

Social Security: _____

Other: _____

Total Income: _____

MEDICAL INFORMATION RELEASE FORM

HIPAA RELEASE FORM

Patient Name: _____ Date of Birth: _____

I authorize the release of information including the diagnosis, records, examination, appointment information rendered to me and claims information. This information may be released to:

Name	Phone Number	Relation
1.		
2.		
3.		
4.		
5.		

Message

FHCC will use the contact information provided on the Annual Eligibility update form and or the Patient Packet to contact the patient.

If unable to reach the patient:

- ☐ We may leave a detailed message
- ☐ Leave a brief message asking to return the phone call
- ☐ Other: _____

Preferred time to contact: _____

Patient Signature _____ Date _____

MANHATTAN FREE CLINIC

FLINT HILLS COMMUNITY CLINIC INC.

Patient Agreement and Treatment Policies

Eligibility

Flint Hills Community Clinic will treat individuals who meet the following eligibility requirements:

- Uninsured (no health benefits or coverage, including Medicaid, Medicare or 3rd party insurance)
- Resident of Riley County and/or the City of Manhattan
- Household income is at or below 200% of the federal poverty level.

Patients will be required to provide the clinic with proof of residency and household income. The clinic reserves the right to request documentation of a patient's eligibility at any time. If a patient no longer meets the eligibility requirements, the clinic will no longer provide services to that individual. Eligibility updates are required annually.

If these conditions are met, all services will be provided at no charge. If there are Lab charges you may be asked for a nominal fee. No one will be denied services based on their ability to pay said fee. These charges will be written off to charity care.

Services

All patients at FHCC are seen by a Physician, Physician's Assistant (PA), Nurse Practitioner (ARNP) or other licensed professional in the state of Kansas. Services are provided free of charge and include primary and acute health care. The clinic cannot treat emergencies or pregnancies. Payment for medical treatment sought outside of the clinic, including emergency room visits, will be the sole responsibility of the patient.

Medications

FHCC is not responsible for the payment of patients' prescriptions. Samples may be given to patients **if available;** however the clinic is not guaranteed to have specific medication samples on site for distribution to its patients. Patients are responsible for obtaining any ongoing medications and the costs associated with them. FHCC does not have stock medications on site for distribution to its patients. Enrollment assistance may be given to patients for various patient assistance programs through the pharmaceutical companies for ongoing prescriptions. If you need help with medications we do offer a PPAP (Pharmaceutical Patient Assistant Program)

Certain medications are available through pharmaceutical companies free to people based upon income. An application will be submitted to the program. If you qualify, you will be contacted to come back to the office to sign the application. Medications will not be given to patients until the application is signed and submitted.

Patients are responsible for notifying their pharmacy if they are in need of a refill. Patients should call their pharmacy no less than **TEN DAYS** before a medication runs out. FHCC providers will NOT prescribe controlled substances.

Referrals

Referrals to specialty physicians are made only when deemed medically necessary by one of our providers. These referrals are made only as available and are not guaranteed. Patients may be responsible for a co-pay or a portion of the cost of these visits and will be required to show documentation of household income. It is the responsibility of the patient to contact the referred specialist regarding their cost prior to the consultation appointment. The patient is responsible to check with the referral if financial assistance is available.

Patient Attendance Policy

Patients are expected to notify the clinic if they cannot keep a scheduled appointment. If the appointment is an evening appointment, notification of a cancelled appointment is to occur by **NOON** on the day of the appointment so that we may give that appointment slot to another patient on our waiting list. If the appointment is an afternoon appointment the cancellation must occur by **4 pm** the day before.

No Show Policy

The clinic Providers and Support Staff give of their personal time to serve you. In honor of their time and clinic resources, it is important to show up when scheduled. A no show is defined not showing for a scheduled appointment without a phone call as stated in the Patient attendance Policy. Two (2) consecutive no shows with require a conversation with our clinic coordinator before rescheduling. Poor attendance history could result in a probationary period and could lead to termination of services.

Privacy Policy

All FHCC staff and volunteers operate according to HIPAA rules and regulations. Written consent is required to release any patient information to other persons or agencies, except as required by law in the cases of court orders, child abuse, life threatening situations and national security issues. Patients' demographic information may be used for the purpose of statistics in reporting to funding sources.

Reporting Policy

FHCC staff and volunteers are required by law to report any suspicion of child, adult, elder or vulnerable person abuse including neglect, emotional, physical or sexual abuse.

Please initial each of the following statements to acknowledge that you have read them and agree to them:

_____ Flint Hills Community Clinic is not an insurance carrier.

_____ Flint Hills Community Clinic operates under the KDHE's Charitable Care Health Program

_____ I will notify the clinic by noon of the day of my (evening) appointment if I cannot keep my scheduled afternoon appointment. I will contact the clinic by 4pm the day previous to my appointment date and understand that if I do not, I will be subject to FHCC's "No Show" policy.

_____ I understand that the FHCC Board of Directors Policy states that NO prescriptions or refills for medications which are classified "Schedule II. III, IV, or V' will not be provided by physicians, nurse practitioners or physicians assistants.

_____ I understand that if I am impaired by drugs or alcohol I may be declined services at the time of the visit.

_____ I understand that services provided at the clinic are free of charge. I understand that if I am referred to a specialist I may be responsible for a portion of assessed fees. I understand that if I seek medical services outside of the clinic, including the Emergency Room, that I will be responsible for any bills incurred.

_____ I understand that I am expected to treat FHCC staff and volunteers with respect. If I am uncooperative, verbally or physically abusive, or behave in an inappropriate manner, I may be dismissed as a patient from the clinic.

_____ I understand that I am expected to be truthful with FHCC staff and volunteers about other medical services that I am receiving and medications or behaviors that may affect my medical well-being.

_____ I understand that FHCC treats individuals who meet the eligibility parameters. I understand that I am responsible for being truthful about my residency, income and insurance status and that if I provide false information about my eligibility that I will be dismissed as a patient from the clinic.

_____ I understand that I am responsible for monitoring my prescriptions and that I need to contact the pharmacy no less than TEN DAYS before my prescription runs out. I understand that if I contact the pharmacy within less than ten days of my prescription running out that I am not guaranteed an appointment to obtain a refill prescription before my medication runs out.

_____ I understand the terms and conditions of the PPAP program and the importance of timely responses to the application process. No medications will be delivered through the program until the application is completed by FHCC and the patient.

I have received a copy of the clinic's Patient Agreement and Treatment policies and I understand and agree to all of the above. I understand that if I violate any of the above-stated agreements, I may be terminated as a patient of the Flint Hills Community Clinic.

_____ _____

Patient or Guardian's Signature Date

By signing below, I acknowledge that I have no health coverage, including Kansas Medicaid, Health Wave, Medicare or any private insurance. I will notify Flint Hills Community Clinic immediately if I obtain any health benefits and understand that once I am covered under a health coverage plan that I am no longer eligible to receive services at Flint Hills Community Clinic.

_____ _____

Patient or Guardian's Signature Date

By signing below, I give Flint Hills Community Clinic permission to verify with Social and Rehabilitation Services that I do not have any health coverage provided through the state of Kansas through Medicaid, Health Wave, or any other government-issued health benefits and to verify with my employer or my spouse's employer that I do not have health insurance or benefits through the employer.

_____ _____

Patient or Guardian's Signature Date

Revised 2/25/2021 RDH

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SMOKING SURVEY

Patient Name: _____ Date:_____

Please answer the following questions regarding your smoking history.

- ☐ Never Smoked
- ☐ Quit Smoking
- ☐ Current Smoker

How Long? _____

What age did you start? _____

Do you want to quit? Y / N

Feel free to add comments regarding any failed attempts/methods, and/or how many times you tried to quit before quitting successfully.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____