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/Guardian Name: _____
(Last) (First) (Middle) (DOB) (SSN)

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

Dependents Name(s)	Relationship	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

NOVANT HEALTH

Financial Assistance Application (Attachment A)

Patient Statement:
(Please use the space below to provide additional information about your financial situation and your ability to pay. If you are unemployed, please provider information related to how you are supporting yourself and who provides food and shelter.)

Addition Comments:

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 may be, but not limited to: copay of paycheck stubs, copy of last year's tax return, or letter from employer stating present salary and hours worked.

Signature of Patient/Guarantor: _____ Date: _____

Signature of Interviewer: _____ Date: _____

For Administrative use only If catastrophic, please document amount that patient is able to pay based on follow-up interview(s):

NOVANT HEALTH

Financial Navigator

Consent for Release of Information

I, _____, authorize the *Financial Navigator* of Novant Health to assist me in completing applications for programs to help cover medical expenses. (Assistance programs may include resources from state, federal or private agencies.) The financial navigator shall have access to obtain and copy any records, and/or information pertaining to but not limited to the physician services. (Patient Initial) _____

The Financial Navigator, Novant Health Michael Jordan Family Medical Clinic, may obtain information from the County Department of Social Services, any information, whether oral or written, regarding Medicaid eligibility. I request that a copy of the approval or Form 5020 be sent to the Financial Navigator assisting me with my application. (Patient Initial) _____

I acknowledge that this consent has been explained to me and is voluntary. I understand that I/Financial Navigator may revoke this authorization at any time, but it will not have an effect on prior actions the Financial Navigator took before the received revocation. (Patient Initial) _____

This consent for release of information will be valid for one year or until final determination of any benefit applications submitted on my behalf. I further understand that by signing below, I am authorizing the release or exchange of these records to obtain medical assistance.

Account: _____ Patient Medical Record #:_____

Patient Name: _____

Patient Legal Guardian Name (if applicable): _____

_____ _____
Patient/Legal Guardian Signature Date

Person receiving/communicating the information:

_____ _____
Signature of Financial Navigator Date

Phone Number: (___) _____-_____ Ext. _____

Health starts in our homes, schools, and jobs. When we know more about you, we can provide better care to support your health and wellness. We cannot guarantee help in all areas, but will do our best to respond to your priorities. **Circle** your response. If you do not want to answer, leave the question **blank.**

	1. Within the past 12 months, did you **worry that your food would run out** before you got enough money to buy more?	Yes	No
	2. Within the past 12 months, did the **food you bought just not last** and you didn't have money to get more?	Yes	No
	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 ("couch-surfing")?	Yes	No
	4. Are you worried about **losing your housing?**	Yes	No
	5. Within the past 12 months, have you been unable to get **utilities** (heat, electricity) when it was really needed?	Yes	No
	6. Within the past 12 months, has **lack of transportation** kept you from medical appointments or from doing things needed for daily living?	Yes	No
	7. Do you feel **physically or emotionally unsafe** where you currently live?	Yes	No
	8. Within the past 12 months, have you been **hit, slapped, kicked, or otherwise physically hurt** by anyone?	Yes	No
	9. Within the past 12 months, have you been **humiliated or emotionally abused** by anyone?	Yes	No
	10. Are any of your needs **urgent?** For example, "I don't have food tonight", "I don't have a place to sleep tonight", "I am afraid I will get hurt if I go home today"?	Yes	No
	11. **Would you like help** with any of the needs that you have identified?	Yes	No

If you would like help:

What steps have you taken to address these needs? Check the box that describes what you have.

	I am using it	I applied for it, but I am not using it yet		I am using it	I applied for it, but I am not using it yet
SNAP or Food Stamps			Medicaid		
WIC			Transportation		
Food Pantry			Disability		
Housing			Employment		
Shelter			Other: _____		

Last four digits of patient's SSN :

NOVANT HEALTH
Michael Jordan Family Medical Clinic

Place patient label here

NOVANT HEALTH

Novant Health Charity Care Program

The charity care program, provided by all Novant Health Affiliates ("Novant Health"), allows qualified low-income patients to receive free care for emergency or medically necessary services (elective services are not included). **Charity care is not health insurance.**

Eligibility Criteria

- Patients must live within the Novant Health catchment area
- Patients must be uninsured and not be eligible for health insurance through an employer, spouse's employer, school, Medicaid, Medicare, worker's compensation, veteran benefits, etc.
- Household income must be within 300% of the Federal Poverty Level.

What happens after you apply?

Please allow at least 14 business days for processing of your application. Once approved, you may be enrolled into the program for up to six months. You must reapply **every six months** to remain in the program. You will receive a letter in the mail confirm your approval.

We must have your application and supporting documents to process and approve you for the program

You must maintain a provider at the clinics listed below as your primary care physician.

What IS covered?

- Services provided by your primary care physician
- Services provided by another Novant Health clinic when referred by your primary care physician

What IS NOT covered?

- Any referral outside of Novant Health
- NH Emergency Department
- Radiologist or third party imaging services
- Anesthesiologist
- Surgery
- Pathologist or laboratory services
- Services billed to the hospital
- Services outside of your primary care physician's office that are not medically necessary

What if I need assistance with services outside of Novant Health?

Our clinics have social workers on staff to assist with linking you to community resources such as dental, vision, food pantries, patient assistance programs, etc. Please feel free to schedule an appointment with a social worker to discuss any linkage community resources you need.

Please consult with your provider regarding medical needs and resources outside of the scope of social work.

NOVANT HEALTH
Michael Jordan Family Medical Clinic
3149 Freedom Dr Charlotte NC 28208
Ph: 980-302-9405

MOVEMENT FAMILY WELLNESS CENTER | Powered by NOVANT HEALTH
Movement Family Wellness Center
2225 Freedom Dr Charlotte NC 28208
Ph: 980-302-9000

NOVANT HEALTH
Michael Jordan Family Medical Clinic- North End
2701 Statesville Ave Charlotte NC 28206
Ph: 980-302-8521

NOVANT HEALTH

Novant Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Novant Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Novant Health:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    1. Qualified sign language interpreters
    2. Written information in other formats (large print, audio, accessible electronic formats, other formats)
2. Provides free language services to people whose primary language is not English, such as:
    1. Qualified interpreters
    2. Information written in other languages

If you need these services, please contact Novant Health interpreter services toll-free at 1-855-526-4411, then select option 3. TDD/TTY: 1-800-735-8262.

If you believe that Novant Health has not provided these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Patient services department
Attn: Section 1557 coordinator
200 Hawthorne Lane
Charlotte, NC 28204

Telephone: 1-888-648-7999 (toll-free)
TDD/TTY: 1-800-735-8262
NovantHealth.org/home/contact-us.aspx

You may file a grievance by mail, in person at the Novant Health facility where care was provided, or by submitting the form at the link above. If you need help filing a grievance, call toll-free, 1-888-648-7999 or TDD/TTY 1-800-735-8262.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available online at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **hhs.gov/ocr/office/file/index.html**

NOVANT HEALTH

***ATTENTION*: Language assistance services, free of charge, are available to you. Call 1-855-526-4411. Select option 3. TDD/TTY: 1-800-735-8262.**

Español (Spanish)	*ATENCIÓN: Los servicios de asistencia lingüísticos, gratuitos, están disponibles para usted. Llame al 1-855-526-4411. Seleccione la opción 3. TDD/TTY: 1-800-735-8262.*
繁體中文 (Chinese)	*注意： 您可以享受免費的語言協助服務。請撥打 1-855-526-4411。選擇選項 3。TDD/TTY：1-800-735-8262。*
Tiếng Việt (Vietnamese)	*CHÚ Ý: Có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi 1-855-526-4411. Chọn tùy chọn 3. TDD/TTY: 1-800-735-8262.*
한국어 (Korean)	*주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 1-855-526-4411 번으로 전화하십시오. 옵션 3 을 선택하십시오. TDD/TTY: 1-800-735-8262.*
Français (French)	*IMPORTANT : Des services d'assistance linguistique gratuits sont à votre disposition. Appelez le +1 855 526 4411. Sélectionnez l'option 3. Dispositif de télécommunication pour sourds et malentendants : +1 800 735 8262.*
العربية (Arabic)	*ملاحظة: خدمات المساعدة اللغوية المجانية متاحة لك. اتصل على الرقم 1-855-526-4411. اختر الخيار 3. جهاز الاتصال الكتابي/الهاتف النصي: 1-800-735-8262.*
Русский (Russian)	*ВНИМАНИЕ: Для вас доступна бесплатная услуга языковой поддержки. Позвоните по телефону 1-855-526-4411. Выберите вариант 3. Текстовый телефон/телетайп: 1-800-735-8262.*
Tagalog (Tagalog – Filipino)	*ATENSYON: May mga libreng serbisyo ng tulong sa wika na available sa iyo. Tumawag sa 1-855-526-4411. Piliin ang opsyon 3. TDD/TTY: 1-800-735-8262.*
فارسی (Farsi)	*توجه: خدمات ترجمه به طور رایگان در اختیارتان قرار دارد. با شماره 1-855-526-4411 تماس بگیرند. گزینه 3 را انتخاب کنید. TDD/TTY: 1-800-735-8262*
አማርኛ (Amharic)	*ማሳሰቢያ፦ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ 1-855-526-4411 ላይ ይደውሉ። አማራጭ 3 ን ይምረጡ። TDD/TTY፦ 1-800-735-8262.*
Deutsch (German)	*HINWEIS: Es stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Wählen Sie +1 855 526 4411. Wählen Sie Option 3 aus. TDD/TTY: 1 800 735 8262.*
اُردُو (Urdu)	*برائے توجہ: آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ 1-855-526-4411 پر فون کریں۔ اختیار 3 چنیں۔ TDD/TTY: 1-800-735-8262۔*
हिंदी (Hindi)	*ध्यान दें: आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-526-4411 को कॉल करें। विकल्प 3 चुनें। TDD/TTY: 1-800-735-8262.*
ગુજરાતી (Gujarati)	*સાવધાન: તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. 1-855-526-4411 પર કૉલ કરો. વિકલ્પ 3 પસંદ કરો. TDD/TTY: 1-800-735-8262.*
বাংলা (Bengali)	*মনোযোগ দিন: আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা লভ্য আছে। 1-855-526-4411 নম্বরে ফোন করুন। বিকল্প 3 নির্বাচন করুন। TDD/TTY: 1-800-735-8262 ।*