CROSSOVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

Crossover Healthcare Ministry Financial Application

Are you PREGNANT? Call 804-564-1348
HIV positive? Call 804-233-5016 ext 129
Recently been in the ER or HOSPITAL?
If YES, please speak with a staff member immediately.

*New Patients-Unfortunately we may not able to accept all new patients seeking healthcare services. New patients will be chosen by lottery during the monthly new patient eligibility screening times (see below).
*Current Patients-Updates are "first come, first serve." We are limited in the number of updates we can process.
***The Ryan White Program for HIV+ patients is a "payer of last resort" program that exists to provide coverage, care, and treatment, for those who have no other source of coverage or face coverage limits.**

****Times & days are subject to change.****

West End (near Regency Mall)	Downtown/Southside
8600 Quiocassin Rd Suite 105 **Richmond, VA 23229** **804-622-0803**	**108 Cowardin Ave** **Richmond, VA 23224** **804-233-5016 ext. 110**
New Patient Screening Times: **The first Tuesday of each month:** 8:00 a.m.	**New Patient Screening Times:** **The first Monday of each month:** 8:00 a.m.
Update Times (For Current Patients): Wednesday: 1:00pm Friday: 8:30am	**Update Times (For Current Patients):** Mondays & Wednesday: 1:30pm

We are excited to serve you in our clinic and to welcome you to the Crossover family!

PLEASE BRING A PHOTO ID AND ONE OF THE FOLLOWING AVAILABLE FORMS OF PROOF OF INCOME TO YOUR FINANCIAL SCREENING FOR ALL INCOME EARNED BY YOUR LEGAL HOUSEHOLD.

Please note that additional documentation MAY BE REQUIRED depending on your financial situation.

Proof of Income	Comments
Pay Stubs	Last ***TWO MONTHS*** of consecutive paystubs from current job
Signed 1040 Tax Return	Must be for most recent tax year (include Schedule C if self-employed)
Letter from Employer	On letterhead that states hours worked per week and hourly rate. If not on letterhead, must be notarized.
Letter from Social Service Agency	Must be on letterhead; includes notice of unemployment benefits
Notarized Support Letter	Must be notarized and signed by person providing financial support
Food Stamp Letter	Most recent award letter. Not the EBT card.

A Guide to Richmond/Metropolitan Area Community Resources

CRISIS LINES		
Suicide Crisis Line	1-800-273-8255	
Crisis Intervention Lines for Mental Health (open 24/7)	Richmond City: 819-4100 Henrico: 261-8484 Chesterfield: 748-6356	For expansive list of HIV services please call **804-233-5016 ext 129**
Crisis and Suicide Hotline for LGBTQ Youth (Trevor Project)	1-866-488-7386	
National Anti-Violence Project	212-714-1141	Bilingual (English/Spanish) Crisis Intervention Hotline

HOSPITALS			
Chippenham JW-Chippenham campus	320-3911	Retreat Hospital	254-5100
Chippenham JW-Johnston Willis campus	330-2000	Richmond Community Hospital	225-1700
Henrico Doctor's Hospital, Parham Rd.	747-5600	St. Mary's Hospital	285-2011
Henrico Doctor's Hospital, Forest Ave.	289-4500	VCU Hospital System (MCV)	828-9000
Memorial Regional Hospital	764-6000		

COUNSELING AND MENTAL HEALTH		
VCU Center for Psychological Services and Development	828-8069 (call for an application to be seen)	612 N. Lombardy St Sliding scale available
Daily Planet	783-0678	517 W. Grace St- mental health services for uninsured
Richmond Behavioral Health	819-4000	107 S. Fifth St- behavioral health services
Henrico Mental Health	727-8500; 727-8515	Henrico residents only-six area locations
Chesterfield Mental Health	768-7203	Chesterfield residents only 6801 Lucy Corr Blvd

MEDICAL		
Virginia Coordinated Care (VCC)	828-0966 www.vcuhealth.org/?id=138&sid=1 (application available online)	Provides access to primary healthcare and coordinates healthcare services for the uninsured; application required
Bon Secours CareAVan	359-9355 www.bonsecours.com/about-us-mission-and-outreach-outreach-care-a-van.html	First-come, first-serve mobile medical clinic; call for locations; some Saturday hours
Health Brigade	358-6343, ext 153 www.fanfreeclinic.org	STI & HIV testing; STI treatment, birth control, reproductive health, physical exams, Trans care
Capital Area Health Network Multiple clinic locations Accepts both Medicaid and Medicare, uninsured on a sliding scale fee, and private insurances.	For all locations, it is best to call this central number: 780-0840.	If you are uninsured, in order to pay based on your income you have two options: •You can bring your **two most recent pay checks** with **two forms of ID** any day to see how much you would be required to pay, based on your income, and then make an appointment •Make an appointment and bring above documents

CrossOver Healthcare Ministry
UNIVERSAL FINANCIAL SCREENING FORM

Today's Date

Last Name	**First Name**	**MI**	**SSN** (If no SSN, write "None")	**DOB** (mm/dd/yyyy)

Email Address:	**Do you have transportation?**	**YES:**	**NO:**

Current Address:	**Apt #**	**City**	**State**	**Zip**

How long have you lived in the Greater Richmond area? _____**Years** _____**Months**	**Are you traveling in the U.S. on a temporary Visa? YES** _____ **NO** _____	**Do you**: (circle one) Own; Rent; Live with family or friends; Live in shelter; Other	**City/County of Residence**

Home Phone (Area Code First)	**Cell Phone** (Area Code First)	**What is your primary language?** English, Spanish, Arabic, Other	**Do you have access to an interpreter?** YES NO N/A

Would you say that you are: American Indian/Alaskan Native, Asian, Black or African-American, Native Hawaiian/Pacific Islander, White Other _____	**What is your ethnicity?** **Hispanic or Latino** _____ **Non-Hispanic or Latino** _____

Are you Married Single Divorced Separated Widowed	**What is your highest level of education?**	**Country of Origin:**	**Are You:** Male Female **TG:** MTF FTM

Emergency Contact Name/Relationship:	**Emergency Contact Number** (area code first)

Household Information: Please list the names and relationships of the patient's family unit living in the house.

Name (ex. John Doe)	**DOB/Age** (mm/dd/yyyy)	**Relationship to Patient** (ex. Self, son, wife)
Head of Household (as stated on tax return)		
Family Members in House		

Did you file taxes in the last year? YES NO **If NO, did someone else claim you on their tax return?** YES NO

If the patient did file taxes in the last year, **and** claims a person on their taxes **who does not live in their household**, please list those persons here:

Employment and Insurance Information: Please list the patient's work status and insurance information below.

What is your employment status? Full-time, Part-time, Seasonal, Disabled, Retired, Student, Dependent, Unemployed	**What is your spouse's employment status? N/A** Full-time, Part-time, Seasonal, Disabled, Retired, Student, Dependent, Unemployed
If you are unemployed, for how long? N/A **Yrs:** **Mos:**	**If your spouse is unemployed, for how long? N/A** **Yrs:** **Mos:**

Are you a veteran of the United States?	YES	NO
If yes, have you applied for benefits?	YES	NO
If yes, are you eligible for benefits?	YES	NO

What is your place of employment? N/A	**Time Employed There:** **Yrs:** _____ **Mos:** _____	**Work Phone**(with area code)**:**
What is your spouse's place of employment? N/A	**Time Employed There:** **Yrs:** _____ **Mos:** _____	**Work Phone**(with area code):

Do you have medical insurance? YES NO **If YES, what type?** Private, Medicaid, Medicare, Veterans	**Do you have Prescription Drug Coverage?** YES NO	**Do you have a VCC Card?** YES NO

Have you ever applied for Social Security Disability? YES NO **If YES, date effective:** _____	**Have you ever applied for Medicaid?** YES NO **If YES, date applied:** _____

When and where did you last receive healthcare services?

Is your healthcare need the result of an accident? YES NO	**If YES, was the accident work-related?** YES NO

Do you receive either of the following? If YES, please circle: SNAP Benefits General Relief

Income Information: Please list the amount of income, before taxes, earned by **ALL PERSONS** in the family unit. Include the following types of income: wages/salary/self-employment, child support/alimony, interest/dividends, disability benefits, retirement benefits, Social Security Income, Unemployment benefits, and any other type of income. Do not include income from loans.

Person Receiving Income	Employer's Name or Source of Income	How Often Do You Receive This?	Amount
		TOTAL MONTHLY INCOME RECEIVED	

If no income is received, how do you provide food and shelter for yourself/family?

If no income is received, how do you provide for other daily living expenses (i.e., help with bills, medications, etc.) for yourself/family?

Proof of Income Provided: Please check which type of proof has been provided to verify income.

Pay Stubs # Provided:	1040 Plus Schedules/Year: SCHEDULE C IF SELF-EMPLOYED	Letter from Employer ON LETTERHEAD
Letter from Social Services Agency	Unemployment Award Letter	Food, Shelter and Support Letter NOTARIZED
Food Stamp Award Letter		

Patient Signature: Please have the patient sign the following certification statement.

Patient: I CERTIFY that that this information is true and accurate to the best of my knowledge. I understand that the information is subject to verification. I understand that if my financial situation changes or I obtain health insurance, my eligibility status will need to be re-evaluated. I understand it is my responsibility to notify THE CLINIC of any changes in my financial situation. I authorize the release of my financial records (including Social Security Number) to RX Partnership, pharmaceutical companies and ***Access Now*** and/or their agents to determine my eligibility for financial assistance for medicines and verification during routine audits. This review is a check on eligibility only. It is not a guarantee that I will receive benefits from any source, and THE CLINIC offers no such guarantees. I understand that falsification of information submitted will jeopardize my consideration for the program.

Signature of Patient/Guardian: _____ **Date:** _____

I certify that based upon the information provided, the individual is eligible for Access Now Servces:

Print name of Screener: _____ **Date:** _____

Signature of screener: _____

**** For Clinic Use Only ****

Monthly Gross Income	Annual Gross Income PROJECTED	Poverty Level 0-138% ( ) 139-200% ( )

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I, _____, hereby certify that I have read the following policies, that I understand them, and that I will abide by them while I am a patient at CrossOver Healthcare Ministry:

- Patient Intake Policy
  - Missed Appointment Agreement
  - Patient Consent Form
  - Receipt of Notice of Privacy- HIPAA
  - Practices Dental Clinic Agreement
- Grievance Procedure
  - Patient Payment Responsibilities
  - Confidentiality Request
  - Controlled Substance Agreement
  - Referrals to Other Providers
- Patient Code of Conduct

_____ _____

Signature of Patient/Parent/Guardian Date

I, _____, hereby certify that I have reviewed the above policies with the applicant/patient.

_____ _____

Signature of Financial Screener Date

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CROSSOVER MINISTRY: ACKNOWLEDGEMENT OF PRESCRIBER SERVICES

Crossover Ministry is able to fill prescriptions for eligible patients through the volunteer services of licensed pharmacists and dispensing physicians who are helping us meet the needs of our uninsured patients. Medication is obtained via donation from various pharmaceutical companies through Rx Partnership and other pharmaceutical company donation programs.

- I understand that my prescription may be filled by a pharmacist or if a pharmacist is not on site, I understand that my prescription may be filled by a physician with a dispensing license.
- I understand that I have the right to take my prescription to a retail pharmacy of my choice. However, Crossover Ministry does not accept responsibility of charges for prescriptions filled at other pharmacies.
- I authorize representatives of Crossover Ministry to share medical and financial information with Rx Partnership, Virginia Healthcare Foundation and pharmaceutical companies (or their designees) as required for eligibility verification during routine audits.
- I hereby authorize a Crossover Ministry representative to sign my name on the necessary pharmaceutical form(s) that may be required for ordering my medications.

Please sign and date below if you understand and agree to the above.

Signature of Patient / Parent / Guardian

Date

Patient Name (Please Print)

Signature of Screener

Date

Access Now

Access Now

Access Now Patient Rights & Responsibilities

I, _____, understand and agree to the following:

(patient name, please print)

- **I will promptly supply all information requested by *Access Now.***
  - **If I see a doctor or receive care in a hospital and am asked to provide any *additional information and/or complete any additional paperwork,* even though I have an *Access Now* card, I will provide this information as requested.**
- **I authorize all individuals and entities to share my medical and financial information with *Access Now.***
- **I authorize *Access Now* to share my financial and medical information with medical clinics, doctor's offices and hospitals to coordinate my treatment.**
- **I will notify *Access Now* and my primary care clinic if my income changes or if I become covered by an insurance plan (including Medicaid/Medicare). I understand that failure to do so may result in disenrollment from the program.**
- **I will keep all appointments with *Access Now* specialists or cancel an appointment at least 24 hours in advance.**
- **I understand that if I miss any two appointments, consecutively or not, without appropriate advance notice, I will be disenrolled from *Access Now* and no services will be available to me any longer.**
- **I will present my *Access Now* identification card to the physician's office at the time of my appointments.**
- **I will behave appropriately while at and in communication with the physician's office and understand that failure to do so will result in disenrollment from *Access Now.***
- **I will follow my doctor's treatment plan, including taking prescribed medications.**
- **I will return to my primary care clinic prior to the expiration date on my enrollment card if I need continued or additional care.**
- **I understand that if I receive a bill related to *Access Now* services I need to call 804-622-8145 to report the bill to *Access Now*.**

By signing below, you indicate that you understand and agree to all patient rights and responsibilities in this document.

Signature of Patient/Guardian: _____ **Date:** _____

☐ I am currently seeing a doctor through *Access Now*.

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HIPAA – Patient Acknowledgment Form

Patient's Name: _____ DOB: _____

Our Notice of Privacy Practices (NPP) provides information about how CrossOver Healthcare Ministry may use and disclose protected health information (PHI) about you.

The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patients' Rights section describing your rights under the law.

Please review the NPP pamphlet thoroughly before signing this acknowledgement form. In the event that terms of the Notice change, a revised copy will be made available to you. By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment, and healthcare operations. You have the right to restrict how PHI is used or disclosed for treatment, payment or healthcare operations.

I give permission for CrossOver Healthcare Ministry to:

- Leave a message regarding an appointment at: _____ (phone)
- Leave a message regarding test results at: _____ (phone)
- Share medical information with (You may choose as many as two persons):

(1) Name _____ Relationship _____
Phone:_____

(2) Name _____ Relationship _____
Phone: _____

Please check off the boxes below: I assume responsibility to inform the practice of any changes in the above information. I have received the most recent Notice of Privacy Practices (NPP) pamphlet.

Please check off the boxes below:

- ☐ I assume responsibility to inform the practice of any changes in the above information.
- ☐ I have received the most recent Notice of Privacy Practices (NPP) pamphlet.

Patient's Signature:	Date:
Relationship to patient if other than self:	

Revised 12/4/17