To renew online, scan this QR code

CROSS OVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

CrossOver Healthcare Ministry Financial Application

Are you PREGNANT? Call (804) 655-2794 ext. 6
HIV positive? Call 804 655-2794 ext. 129
Recently been in the ER or HOSPITAL?
If YES, please speak with a staff member immediately.

- Current Patient Renewals and New Patients: An appointment is required.
- **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.**

Application screening **by appointment only**

Locations

Henrico (near Regency Mall)
8600 Quioccasin Rd. Suite 105
Richmond, VA 23229
(serves clients 3 years and older)

Richmond
108 Cowardin Avenue
Richmond, VA 23224
(serves clients 14 and older)

For New Patient Eligibility Screening and Eligibility Renewals

Call (804) 655-2794 option 6

PLEASE BRING A PHOTO ID, RECENT 1040 TAX FORM IF APPLICABLE, AND ANY OF THE FOLLOWING PROOFS OF INCOME YOU HAVE FOR ALL INCOME EARNED BY YOUR LEGAL HOUSEHOLD TO YOUR FINANCIAL SCREENING APPOINTMENT.
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 8 paystubs for weekly pay / 4 paystubs for every other week pay
Signed 1040 Tax Return	Must be for most recent tax year (include Schedule C if self-employed)
Letter from Employer	The letter must can include a professional letterhead that states hours worked per week, hourly rate, pay frequency, title and signature of your supervisor. If not on letterhead, it must be notarized, or with a business card naming your supervisor. The date of the letter should be within one month of the date of your appointment.
Letter from Social Services or Social Security Administration Agency	Must be on letterhead; includes notice of unemployment, disability, or retirement benefits
Notarized Support Letter	Must be notarized and signed by the person providing financial support. The date of the letter should be within one month of the date of your appointment.
SNAP Benefits Award Letter	Most recent award letter. Not the EBT card.

****** USE BLACK INK ONLY TO COMPLETE APPLICATION ******

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: (804) 819-4100 Henrico: (804) 727-8484 Chesterfield: (804) 748-6356	For complete list of HIV services please call (804) 655-2794 opt. 6
Crisis and Suicide Hotline for LGBTQ Youth (Trevor Project)	1-866-488-7386	
National Anti-Violence Project https://avp.org/ncavp/	(212) 714-1141	

HOSPITALS	
CJW Chippenham Campus (804) 483-0000	Retreat Doctor's Hospital (804) 254-5100
CJW Johnston Willis Campus (804) 483-5000	St. Mary's Hospital (804) 285-2011
John Randolph Medical Center (804) 541-1600	Memorial Regional Medical Center (804) 764-6000
Henrico Doctors' Hospital Forest Campus (804) 289-4500	Richmond Community (804) 225-1700
Henrico Doctors' Hospital Parham Campus (804) 747-5600	St. Francis Medical Center (804) 594-7300
VCU Medical Center (804) 828-9000	

COUNSELING AND MENTAL HEALTH		
VCU Center for Psychological Services and Development	(804) 828-8069 (call for an Application) to be seen)	612 N. Lombardy St Sliding scale available
Daily Planet	(804)783 2505	517 W Grace St. – Mental health services for uninsured.
Richmond Behavioral Health	(804) 819-4000	107 S. Fifth St.- behavioral health services
Henrico Mental Health	(804) 727-8500 For same day services: (804) 727-8515	Henrico residents only- six area locations
Chesterfield Mental Health	(804) 748-1227	6801 Lucy Corr Blvd. Chesterfield residents only

MEDICAL SERVICES		
Bon Secours Care-A-Van	New and established patients seeking a same day appointment should call: 804-545-1923 from 7:00 a.m. - 8:30 a.m. Tuesdays and Thursdays. For additional information, please call our office at: 804-545-1920, (804) 359-WELL	
Health Brigade	(804) 358-6343 https://www.healthbrigade.org	STI & HIV testing; STI treatment, birth control, reproductive health, physical exams, Trans care
Capital Area Health Network	For all locations, it is best to call this central number: (804) 780-0840	Multiple clinic locations Accepts both Medicaid and Medicare, uninsured on a sliding scale fee, and private insurances.

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** **In USA?** ____ 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** _____	**Religion?** _____ ☐ Decline to answer

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	**Which is your home clinic?** Henrico Downtown (RIC)

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 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 Services:

Signature of Screener: _____ **Date** _____

(Print Name of Screener): _____

Monthly Gross Income	**** For Clinic Use Only **** **Annual Gross Income** PROJECTED	**Poverty Level** 0-138% ( ) 139-200% ( )

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CLINIC POLICIES

AKNOWLEDGMENT OF PRESCRIBER SERVICES

CrossOver HealthCare 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.
- 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 Healthcare 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 Healthcare Ministry representative to sign my name on the necessary pharmaceutical form(s) that may be required for ordering my medications.

PATIENT INTAKE POLICIES AND PATIENT RESPONSIBILITIES

- Missed Appointments
- Missed Dental Appointments
- Controlled Substance Policy
- Grievance Procedure
- Patient Consent
- Receipt of Notice of Privacy
- Care Contributions
- Outgoing Referrals
- Patient Code of Conduct

My signature below certifies that I have read, understand, and will abide by the policies included in this document.

_____ _____
Signature of Patient/ Parent/ Guardian Date

_____ _____
Signature of interviewer Date

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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.

By signing this form, I also give permission to the person(s) listed on the table to receive Private Health Information (**excluding mental health information)** and other authorizations as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting my request to change, add, or terminate such permission in writing.

Name of Individual and relationship to patient	Telephone	Check for permission or write comment.
		☐ Medical/dental/vision record pick up ☐ Request appointment or clinical information ☐ Medical equipment pick-up ☐ Other:_____
		☐ Medical/dental/vision record pick-up ☐ Request appointment or clinical information ☐ Medical equipment ☐ Other:_____

I give permission for CrossOver Health Care Ministry to leave a message (voice/text) on _____ for:

- ☐ appointment reminder
- ☐ lab/imaging results
- ☐ other:_____

For the continuity of your health care, do you authorize us to share your health information with other health care providers through PRIZMA, a shared information platform? ☐ Yes ☐ No

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).
- ☐ I have received the most recent Patient Resource Guide.
- ☐ I hereby authorize a CrossOver Healthcare Ministry representative to sign my name or make corrections on the necessary Access Now form(s) that may be required to maintain continuity of my healthcare.

Patient's Signature: _____Date: _____

Relationship to patient if other than self: _____

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*.

Authorization to Share Health Information and Records

Patient Name (please print): _____

Patient DOB: _____

I authorize Access Now, Inc. to discuss and share my Protected Health Information (PHI), health records and health information with the following person(s):

Name:	Relationship:	Phone Number:

As the person signing this authorization, I understand that it will remain in effect until I submit a new authorization form to Access Now, Inc., which I may do at any time. I understand that if a new authorization is submitted to Access Now, Inc., any previous authorization will be cancelled and no longer valid. I also understand that once information is shared by Access Now, Inc. with an authorized person, the information may not be kept to the same privacy standards by the recipient.

Signature of Patient, Guardian, or Legal Representative: _____

Relationship to patient (if not the patient):

_____

Date of Signature: _____

For Access Now use only

Date Access Now Received Authorization: _____

Date Authorization Cancelled: _____

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SELF DECLARATION OF VIRGINIA RESIDENCY

CrossOver Healthcare Ministry (CrossOver) serves patients who are residents of Virginia who meet specific eligibility requirements for household income and insurance coverage. Due to capacity restraints, CrossOver cannot accommodate patients who are visiting or temporarily residing in Virginia.

As a patient at CrossOver, I, _____
(Patient's First and Last Name)
declare that Virginia is my primary state of residence and constitutes my permanent and principal home, for legal purposes. Furthermore, I declare that I intend to be permanent resident of Virginia (and I reside in Virginia for at least 7 months of the year) and I am not here on a tourist visa and do not anticipate moving to another state or country for the foreseeable future.

_____ _____
Signature of Patient/ Parent/ Guardian Date

"Primary State of Residence" is defined as: the state of a person's declared fixed permanent and principal home or domicile for legal purposes.

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We want to make sure that we provide the best care possible. Below are some non-medical questions to support your health goals and meet your needs. Your responses are completely confidential.

TODAY'S DATE: _____

Full Name: _____ **Date of Birth:** _____

Social Determinants of Health

1. Are you having difficulty affording food or need assistance with food stamp application? ☐YES ☐NO
2. Are you having trouble affording a place to live? ☐ YES ☐ NO
3. Are you experiencing anxiety or depression? ☐ YES ☐ NO
4. Are you having family trouble which might be affecting your health? ☐ YES ☐ NO
5. Are you or your children having trouble in school? ☐ YES ☐ NO ☐ Not Applicable
6. Do you ever feel unsafe in your home for any reason? ☐ YES ☐ NO
7. Do you have access to Internet? ☐ YES ☐ NO

Our staff is available to assist with your social needs by connecting you with resources. *If you answered <u>YES</u> to questions 1-6, would you like an appointment?* ☐ YES ☐ NO

Patient Health Questionnaire – PHQ2

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

- ☐ **0** = Not at all
- ☐ **1** = Several days
- ☐ **2** = More than half the days
- ☐ **3** = Nearly every day

Feeling down, depressed, or hopeless

- ☐ **0** = Not at all
- ☐ **1** = Several days
- ☐ **2** = More than half the days
- ☐ **3** = Nearly every day

☐ *I decline to answer questions*