To renew online, scan this QR code

CROSSOVER Healthcare Ministry

COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

CrossOver Healthcare Ministry Financial Application for MINORS

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 FOR MINORS

Today's Date

Minors:Last Name	**First Name**	**MI**	**SSN of minor** (or write "None")	**DOB of minor** (mm/dd/yyyy)

Guardians Email Address:	**Does the minor have transportation?** **YES:** **NO:**

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

Is the minor currently enrolled in school?	**What school does the minor attend?**	**Do you need help enrolling the minor in school?**	**Is the minor having problems in school?**

How long has the minor lived in the Greater Richmond area? ____ **Years** ___ **Months** **In USA?** ____ Years ___ Months	**Is the minor traveling in the U.S. on a temporary Visa?** **YES** **NO**	**Does the family**: (circle one) Own; Rent; Live with family or friends; Live in shelter; Other:	**City/County of Residence of the minor**

Guardians Home Phone	**Guardians Cell Phone**	**What is the minors primary language?**	**Does the minor have access to an interpreter?** YES NO

Race of minor: American Indian/Alaskan Native, Asian, Black or African-American, Native Hawaiian/Pacific Islander, White Other _____	**Ethnicity of minor?** **Hispanic or Latino** _____ **Non-Hispanic or Latino** _____	**Religion?** _____ ☐ Decline to answer

Minors guardians are: Married Single Divorced Separated Widowed Free Union	**Is the minor currently employed?**	**Country of Origin of the minor**	**Minor is:** Male Female **TG:** MTF FTM

Emergency Contact Name/Relationship to minor:	**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)

Was the minor claimed as a dependent on taxes last year? YES ____ NO ____

If the answer is YES, who? Parent _____ Guardian _____ Other _____

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

What is the employment status of the minor's mother/ guardian? Full-time, Part-time, Seasonal, Disabled, Retired, Student, Seasonal, Disabled, Retired, Dependent, Unemployed		**What is the employment status of the minor's father/ guardian?** Full-time, Part-time, Seasonal, Disabled, Retired, Student, Seasonal, Disabled, Retired, Dependent, Unemployed	
How long have they been employed here?	**Work phone number:**	**How long have they been employed here?**	**Work phone number:**

Does the minor have medical insurance? YES NO	**Does the minor have prescription Drug Coverage?**	**Minors home clinic?** Henrico Downtown (RIC)

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

When and where did the minor last receive healthcare services?

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

For the patient's parent or legal guardian:

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

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 CROSSOVER HEALTHCARE MINISTRY of any changes in my financial situation. I authorize the release of my financial records (including Social Security Number) to RX Partnership, pharmaceutical companies Direct Relief, ***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 CROSSOVER HEALTHCARE MINISTRY offers no such guarantees. I understand that falsification of information submitted will jeopardize my consideration for the program.

Signature of Patient/Legal Representative: _____ **Date:** _____

I certify that based upon the information provided, the individual is eligible for Access Now Services, Direct Relief, RxPartnership and the pharmaceutical assistance programs that assist Crossover clients:

_____ _____

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% ( )

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/Legal 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: _____

CROSSOVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

CLINIC POLICIES

AKNOWLEDGMENT OF PRESCRIBER SERVICES / SIGNATURE AUTHORIZATION

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

- I understand that my prescription will be filled by a licensed, volunteer pharmacist.
- I understand that I have the right to take my prescription to a retail pharmacy of my choice.
- However, CrossOver Healthcare Ministry does not accept responsibility of charges for prescriptions filled at other pharmacies.
- I understand that, in order for my medications to be provided by the CrossOver Pharmacy, my financial screening must have been updated within the past 12 months.
- I authorize representatives of CrossOver Healthcare Ministry to share medical and financial information with Rx Partnership, the Virginia Healthcare Foundation, Direct Relief, Americares and pharmaceutical assistance programs (or their designees) as required for eligibility verification during routine audits.
- When appropriate, I authorize CrossOver Healthcare Ministry to transport my medication between the two clinics in order to facilitate medications pick up.
- I hereby authorize a CrossOver Healthcare Ministry representative to sign my name and date necessary form(s) that may be required for ordering my medications or scheduling medical appointments and/or tests.

_____ _____
Signature of Patient/ Parent/ Legal Guardian Date

_____ _____
Signature of interviewer Date

CROSSOVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

CLINIC POLICIES

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/ Legal Guardian Date

_____ _____
Signature of interviewer Date

CROSSOVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

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: _____

CROSSOVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

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 _____

(print first and last name)

declare that **Virginia is my primary state of residence** and constitutes my permanent and principal home, for legal purposes. My current address is

_____

(*address*)

_____

(address)

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.

_____ _____

(Patient Signature) *(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.

CROSSTOVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED

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

Spiritual Care

We have team members who may offer spiritual care (such as prayer or sharing scripture.) Would you like to be offered this optional type of care? ☐ YES ☐ NO ☐ Declined to answer

Proxy Consent for the Treatment of Minors

Purpose: This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and services at the CrossOver Healthcare Ministry clinics.

For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent. If you would like to appoint a proxy decision maker, please review and complete the following form authorizing a proxy decision maker to consent to and authorize medical treatment or services for and to be involved in the care of a minor child.

AUTHORIZATION:

I (We)_____ hereby appoint and authorize the following
Print name(s) of legal guardian(s)

individuals to bring my child(ren) in for evaluation and treatment of any acute or chronic medical condition, and for routine, well visit care. The individuals so named are adults over the age of 18. I authorize the following individuals listed below to provide informed consent on behalf of my minor child for any treatment or medications recommended or prescribed by my child's clinician including but not limited to routine vaccinations, allergy shots or intramuscular/intravenous antibiotics in accordance with guidelines and protocols. I authorize the following people listed below to receive released medical information on my minor child including, but not limited to laboratory or test results.

Name: _____ Phone:_____ Relationship_____

Name: _____ Phone:_____ Relationship_____

Further, I (We) authorize CrossOver Healthcare Ministry and its staff and volunteer personnel to deliver routine medical care to my child(ren), listed below. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, xrays, lab work (examples include: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, cleaning of minor burns, minor suturing of lacerations, removal of simple cysts, contraceptive care, and incision and drainage of abscesses).

If additional space is needed, please attach a separate sheet of paper.

(Please Print)

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given (If none, state "none")

_____

_____

Parental Contact information for questions regarding treatment:

Parent's Name:_____Phone:_____Relationship_____

Parent's Name:_____Phone:_____Relationship_____

I hereby indemnify and hold harmless CrossOver Healthcare Ministry, and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to CrossOver Healthcare Ministry or restricted by time frame as noted above. *Only one parent's signature is required.*

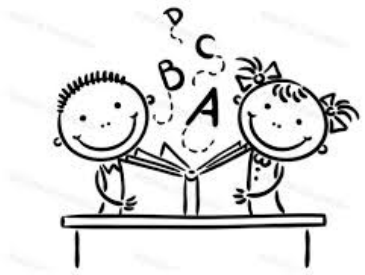
_____ _____

Signature of Parent/Legal Guardian **Date**

_____ _____

Signature of Parent/Legal Guardian **Date**

CROSS OVER
Healthcare Ministry
COMPASSIONATE HEALTHCARE FOR PEOPLE IN NEED



Our Pediatric Care Coordinator can assist with the following:

- Help with school enrollment.
- Open communication with your child's teachers and the school.
- Assist with financial aid applications for medical bills.
- Help you with enrollment into SNAP, Medicaid.
- Assist with resources.

If this support is needed, please call the office and schedule an appointment with the Pediatric Care Coordinator. Our phone number is 804-655-2794

Nuestra coordinadora de Pediatría le puede ayudar con lo siguiente:

- Inscripción en la escuela más cercana.
- Comunicación con los maestros de su hijo y la escuela.
- Solicitud de ayuda financiera para las facturas médicas.
- Inscripción en SNAP y Medicaid.

Si necesita este apoyo, llame a la oficina y programe una cita con la coordinadora de pediatría. Nuestro número de teléfono es 804-655-2794

Nossa coordenadora de cuidados pediátricos pode te ajudar com o seguinte:

- A matricular o seu filho(a) na escola
- Estabelecer comunicação com os professores e a escola do seu filho (a).
- Aplicação para programas de assistência financeira para resolver as contas médicas do seu filho(a)
- Aplicação do SNAP e Medicaid.
- Encontrar recursos para atender as necessidades do seu filho(a)

Se este apoio for necessário, ligue e agende uma consulta com o Coordenador de Cuidados Pediátricos. Nosso número de telefone é 804-655-2794

:يلي ما في المساعدة لدينا الأطفال رعاية لمنسق يمكن

.بالمدرسة الالتحاق في المساعدة
.والمدرسة طفلك معلمي مع مفتوح تواصل
.الطبية للفواتير المالية المساعدة طلبات في المساعدة
.Medicaid و SNAP في التسجيل في مساعدتك
.الموارد في المساعدة
هو هاتفنا رقم .الأطفال رعاية منسق مع موعد وتحديد بالمكتب الاتصال فيرجى ، الدعم هذا إلى حاجة هناك كانت إذا