MercyHealthClinic

We welcome you to become a patient at Mercy!

HOW TO APPLY

The application packet can be picked up at Mercy during clinic hours:

Monday to Wednesday: 8:30 am – 4:00 pm
Tuesday and Thursday: 8:30 am – 7:00 pm

Mercy staff will accept and review applications with documents on:

Wednesdays: 12:00 pm – 3:00 pm
Fridays: 9:00 am – 12:00 pm

WHO IS ELIGIBLE?

You may be eligible if:

- You live in Montgomery County
- You are 18 years old or older
- If you don't qualify for Health Insurance
- You have a low income

WHAT YOU NEED TO BRING

PHOTO ID **(Passport, license, etc)**

PROOF OF INCOME

(Bring at least one)

- Current W2/Signed Tax return or your last 4 paystubs) OR
- Unemployment Letter OR
- Letter from your employer OR
- Letter of financial support from a friend or family member.

PROOF YOU LIVE IN MONTGOMERY COUNTY

(Bring at least one)

- Recent utility bill (gas, electricity, water, Cable/internet)
- Driver's license or Maryland State ID
- Lease or mortgage statement
- Current W2/Signed Tax Return
- Letter from your landlord with a copy of utility bill (gas, electricity, water)
- A letter from the state or county

ELIGIBILITY STAFF PAPERWORK

New /Reapplying Patient

Full Name (as per ID) / *Nombre Completo* _____ DOB/*Fecha de Nacimiento* _____

1. Are you a Greencard holder for **less** than **5 years**?/***Tiene residencia permanente menos de 5 años?*** ☐ *Yes / Sí* ☐ *No*

2. Do you have a Social Security Number?/***¿Tiene un número de Seguro Social?*** ☐ Yes / Sí ☐ No

If through TPS, NACARA, DACA, or other, specify:/***Si es por TPS, NACARA, DACA, u otro, especifique***: _____

3. Do you have health insurance? ***¿Tiene o ha tenido seguro médico en el pasado?*** ☐ Yes / Sí ☐ No

If yes, name of the insurer:/ ***Si contestó sí, nombre del seguro:*** _____

4. Have you been a patient at another clinic in the past 2 years?/ ***¿Ha sido paciente de alguna otra clínica en los últimos 2 años?*** ☐ Yes / Sí ☐ No *If yes, name of the clinic:/**Si contestó sí, nombre de la clínica***:_____

5. Are you financially dependent on someone else? /¿Dependes económicamente de otra persona? ☐ Yes / Sí ☐ No

********** (FOR MERCY STAFF USE ONLY) **********

☐ ***Full-Time*** ☐ ***Part-Time*** ☐ ***Unemployed***

Total combined annual income of all employed individuals $_____ **Total # of people** _____

Notes: _____

Please check the documentation provided for proof of address, income, and age for each Patient.

Proof of Address

☐ Driver's License
☐ W2/Tax Return/1099
☐ Letter: County or State
☐ Other: _____
☐ Letter: Landlord + Utility Bill within **60 days**
☐ Recent paystubs
☐ School Records
☐ Maryland State ID
☐ Mortgage/Lease
☐ Utility Bill within **60 days** (gas, electric, water, cable/internet)

Proof of Age

☐ Passport
☐ Driver's License/MD ID
☐ Other: _____

Proof of Income

☐ DHHS Income Declaration Form
☐ Recent Paystubs
☐ W2/Tax Return/1099
☐ Income Letter: Employer/Disability/Unemployment
☐ No Income: Letter of Support from Family or Friend
☐ Other: _____

NOTE: The patient is missing the following documentation:

___ Proof of address: _____
___ Proof of ID: _____
___ Proof of income: _____

Staff Name: _____ **Date:** _____

Data Entry Name: _____ ☐ *completed, scanned, & added to excel* **MRN#**_____

MONTGOMERY COUNTY SAFETY-NET PROGRAMS APPLICATION

COUNTY OFFICIAL USE ONLY:

eICM Contact ID: _____

Case Number: _____

Head of Household Name (Last, First, Middle)	Home Telephone	Work Telephone	Cell Telephone

Where Do You Live? (Number and Street)	Apt. #	City	State	Zip Code

Mailing Address (If different from home address)

What language do you speak? ☐ **English** ☐ **Spanish** ☐ **Amharic** ☐ **French** ☐ **Korean** ☐ **Mandarin** ☐ **Vietnamese** ☐ **Other** _____

Are you or anyone in your household pregnant? ☐ **Yes** ☐ **No** **If yes, who?** _____ **Due Date** _____

Have you ever received a county health program benefit program? ☐**Yes** ☐**No** Under what name? _____

What is your sexual orientation?

SECTION A. HOUSEHOLD MEMBERS

Fill in the blanks for all the people in your household. Check **YES** for each person you are applying for. Check **NO** for each person you are not applying for. Check services you are requesting.

Please complete for each person who has a Social Security number

APPLYING FOR	NAME (Last, First, Middle)	RELATION TO YOU:	DATE OF BIRTH MM/DD/YY	GENDER	MARITAL STATUS	*RACE (Indicate below for each person)	*ETHNICITY	SOCIAL SECURITY NUMBER (SSN)
☐ MONTGOMERY CARES ☐ CARE FOR KIDS ☐ SENIOR DENTAL				**M** =Male **F**= Female **NB**=Nonbinary **GQ** = Genderqueer/ Genderfluid **MTF** = Transwoman/ woman of transgender experience **FTM** = Transman/ man of transgender experience	**M** = Married **S** = Single **D** = Divorced **P** = Separated **W** = Widowed	A = Asian B = Black/African American C = White N = American Indian or Alaska Native P = Native Hawaiian or Pacific Islander (You may select more than one code) MENA = Middle Eastern or North African	H/L = Hispanic/ Latino N/L = Non-Hispanic/ Non-Latino	
☐ Yes ☐ No		SELF					☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	

***You do not have to give information about your race/ethnicity. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter codes for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.**

SECTION B. ADDITIONAL INFORMATION

Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Qualified Health Plan (QHP) ☐ Medicare ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Qualified Health Plan (QHP) ☐ Medicare ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Qualified Health Plan (QHP) ☐ Medicare ☐ Private-Payer ☐ Employer-Based

SECTION C. EARNED INCOME

Does anyone in your household receive any income from employment? ☐ Yes ☐ No If yes, list all gross income (from full or part-time employment, self-employment, babysitting, odd jobs, day work, roomer/boarder payments)

NAME (Last, First, Middle)	EMPLOYER	RATE OF PAY (HOURLY)	NUMBER OF HOURS WORKED	GROSS AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED WE = Weekly BW = Bi-weekly MO = Monthly	JOB START DATE (MM/DD/YY)	JOB END DATE (MM/DD/YY)	STUDENT STATUS (Full or Part-time)

SECTION D. UNEARNED AND OTHER INCOME

List any other income received such as alimony, child support, pension, Social Security, income received from renting property to others, and benefits (retirement, strike benefits, unemployment, veterans, workers compensation). Include out-of-state benefits.

PERSON RECEIVING INCOME	TYPE (For benefits, Include Claimant ID#)	GROSS AMOUNT RECEIVED	HOW MANY TIMES A YEAR?

SIGNATURE SECTION

I certify that the information I have provided above is true to the best of my knowledge and I give permission for Montgomery County to make any necessary contacts to check my statements. I have read and agree to the rights and responsibilities in this application packet. I know that I can be penalized if I knowingly give false information, and I declare under penalty of perjury that I do not have health insurance coverage and the facts I state in this application are true, correct, and complete to the best of my ability, belief, and knowledge.

Signature of Applicant/Recipient	Print (Name)	Date

Authorization Form for Family Members/Friends

Patient Name: _____ DOB: _____
Email: _____ Cell #: _____

I, _____, give permission to all my health care and medical services providers to disclose and release my protected health information described below to:

Name(s):	**Relationship:**	**Phone Number:**
_____		_____
_____		_____

Health Information to be disclosed *(Check all that apply)*:

☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

☐ My complete health record, as above, except for the following information (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

Appointment time that works best with you: (check one)

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

This authorization shall be effective until: (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____ unless I revoke it.

(**NOTE:** You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Signature **Date**

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Your PHI may be used and disclosed by Mercy Health Clinic, our office staff and others outside of our office involved in your care and treatment to provide health care services to you.

The following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. We will also disclose protected health information to other physicians who may be treating you.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider.

Health Care Operations: We may use or disclose, as needed, your protected health information to support the clinic's business activities. These activities include quality assessment activities, employee review activities, training medical students, fundraising activities, and conducting or arranging for other business activities. We will share your protected health information with third party "business associates" that perform various activities (for example, billing transcription services) for our practice. We may use or disclose your protected health information, as needed, to provide you with information about treatment alternative or other health-related benefits and services that may interest you.

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange to provide faster access, better coordination or care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.

I _____ (Patient Name) have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my medical information. Accordingly, I knowingly and voluntarily authorize any Mercy Health Clinic Member to use or disclose my medical information in the manner described above. I understand and agree that this Authorization applies only to the extent that an Authorization is required by law in order to Mercy Health Clinic Members to use or disclose my medical information in the manner described.

_____	_____	_____
Full Name (as per ID)	**Signature**	**Date**

PATIENT'S RIGHTS AND RESPONSIBILITIES POLICY

1. I understand that Mercy Health Clinic (MHC) is not a government program or an insurance company, but a non-profit clinic dependent on donations and grants to cover its operating costs.
2. While I understand that I will not be denied care for the inability to pay, I acknowledge that the clinic appreciates a voluntary cash contribution of **$20.00** for primary care and lab visits, and **$30.00** for specialty care.
3. I understand that there is a **$50.00** fee for missing a scheduled appointment without providing proper notice **("No Show").**
4. I understand that once my appointment is scheduled, it is my responsibility to remember the date and time and to keep the appointment.
5. I understand that if I need to cancel or reschedule an appointment, I must call or leave a message at least 24 hours in advance at 240-773-0300 / 240-773-0320 or email appointments@mercyhealthclinic.org.
6. I understand that the following behaviors may result in termination from clinic services or external resources:
    a. ***Noncompliance with treatment as instructed by the physician***
    b. ***Misconduct or rudeness***
    c. ***Misuse of services***
    d. ***Failure to show up ("No Show") for any scheduled appointments***
7. I understand that MHC is not responsible for any medical bills incurred from outside doctors or specialists unless I have received a referral from Mercy Health Clinic and followed the given instructions.
8. I understand that MHC does not provide comprehensive medical care and operates only on the following days and times:
    a. **Clinic/Pharmacy Hours:**
        Monday and Wednesday: 8:30 am - 5:00 pm
        Tuesday and Thursday: 8:30 am - 8:00 pm
        Closed on Fridays- Montgomery Cares Program Screening ONLY
    b. **Laboratory Hours:**
        Monday and Wednesday: 7:30 am - 10:30 am
    c. **Montgomery Cares Program Screening Hours:**
        Wednesday: 12:00 pm - 3:00 pm
        Friday: 9:00am-12:00pm
9. I understand that the MCares program is not available to patients who qualify for health insurance. If I have a Social Security number, I must apply for Maryland Health Connection and provide an approval or denial letter to continue receiving services under the MCares program.
10. I understand that MHC accepts the following insurances: Medicaid, WellPoint, Maryland Physician Care, and CareFirst BCBS.
11. I understand that it is my responsibility to renew my eligibility with the MCares program every year before the expiration date. I must provide proof of ID, proof of address, and proof of income. Failure to renew my eligibility will prevent me from keeping my scheduled appointments with the physician.
12. I understand that it is my responsibility to inform MHC of any changes to my income, address, or phone number.

_____	_____	_____
Full Name (as per ID)	**Signature**	**Date**

MEDICAL RECORD RELEASE FORM

Full Name (as per ID) /*Nombre Completo*: _____

SS#: _____ DOB/*Fecha de Nacimiento*: _____

Address/*Dirección*: _____

DO NOT WRITE BELOW THIS LINE / NO ESCRIBA DEBAJO DE ESTA LÍNEA (STAFF USE ONLY)

Name of Provider, Hospital, or Clinic:

_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

If release/request of records is to be sent to Mercy Health Clinic, we would appreciate a summary of diagnostic studies, laboratory reports, x-rays, and any other pertinent data.

Obtain Records From ☐ **Send Records To** ☐

The release/request of records is to be sent to:

Mercy Health Clinic
7 Metropolitan Court, Suite 1
Gaithersburg, MD 20878
Phone: 240-773-0300
Fax: 240-773-0308

Patient authorizes the release of his/her medical records as provided above:

_____ _____

Signature **Date**