Cape Fear HealthNet
Bridging the Gap for the Uninsured

1601 Doctors Circle
Wilmington, NC 28401
Phone: (910) 399-2751
Fax: (910) 399-2756

Welcome To Cape Fear HealthNet!

We are here to help you get connected to a medical home. To do that, we need the items checked below to process your enrollment. If you have questions or need assistance gathering this information, please let us know.

We want to make this process as easy as possible to ensure you get the health care you need!

- **Proof of identification:**
  - **Driver's license, State ID, Passport or Green Card (one of these) or;**
  - **Two Other documents with identifying information**

- **Proof of Income:**
  - **Disability statement**
  - **Letter of support**
  - **Copy of prior year tax return,**
  - **Wage stubs (at least one month)**
  - **Self-employed – Tax Return or Written Statement or Bank Records or Form 1099**
  - **If denied Medicaid or Medicare, please bring denial letter**

- **Proof of current residency:**
  - **Lease, utility bill, bank statement, etc., with your name and the address of where you currently live**

- **Proof of Assets:**
  - **Current bank statement**

Revised 12/15/21

Appt Date: _____ **Time:**_____ **Enrollment Specialist:**_____

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

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

Dependent Name(s)	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
Signature of Director		Date:	Approved	Denied
Signature of EVP/VP		Date:	Approved	Denied

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910-399-2751

Please list below the additional people living in your home.

	Name	Date of Birth	Relationship to Patient
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

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Bridging the Gap for the Uninsured

New Hanover Regional Medical Center

Name: _____
(Last Name) (First Name) (Middle Initial)

DOB: _____ MR#: _____

Acct#: _____

STATEMENT OF SUPPORT/ASSISTANCE

This is to certify that I am/was providing the following type of support and assistance to:

_____
(Patient Name)

	Yes	No
Food:	___	___
Shelter:	___	___
Cash:	___	___

Amount per month: $_____

From: _____ To: _____
(Month/Year) (Month/Year)

At this address: _____
(Street Address)

_____
(City, State, Zip Code)

I am not responsible, nor able to pay, for any hospital or medical expenses for him/her.

_____ _____
Date Signature

_____
Print Name

Relationship to Patient: _____

Telephone # (including area code): _____

Address (if different from above): _____

_____

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Bridging the Gaps for Health Access

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Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Authorization for Use and Disclosure of Protected Health Information

1.Disclosure Authorized. I authorize all of my health care providers, health plans, and case management service providers, and all other persons and entities who have provided, or may be providing me with any type of health care, health insurance or case management services, to disclose all of my protected health information to Cape Fear HealthNet ("CFHN"), and its partners: **Cape Fear Clinic, Good Shepherd Center, MedNorth, New Hope Clinic, Novant Health/New Hanover Regional Medical Center, Black River Family Practice, New Hanover Medical Group, Christ Community Clinic and Coastal Horizons Health with the exception of psychotherapy notes.** I further authorize CFHN and partners to share any protected health care information it obtains from these health care providers, health plans, health insurers and case management service providers to other health care providers, health plans, health insurers, and case management service providers and to all other persons and entities who may be contacted for a health care referral, and to appropriate social service agencies. I authorize CFHN and partners to verify financial information with appropriate service providers and any current or previous employers as is necessary to complete eligibility verification. CFHN staff or partner may also discuss my case with the following persons:

_____ _____ _____

Name Relationship Phone Number

CFHN or partner staff may leave a message on my voice mail at home/work or someone else: **Y/N**

CFHN may communicate with through phone/text/email: **Y/N**

2. Purpose of Authorization. The purpose of this authorization is to enable Cape Fear HealthNet and partners to assist me in managing my medical condition and connect me with other community resources, partners, and medical providers, for services which I might need.

3. Expiration Date. This authorization will expire one (1) year from the above date unless revoked by me prior to that date. This authorization may be revoked by me in writing at any time.

4. Required Disclosures. I understand that any information used or disclosed under this authorization may be subject to re-disclosure and may no longer be protected under federal privacy rules.

All information provided is true and correct to the best of my knowledge.

_____

Patient Signature **Date**

I certify I will contact/notify the facility in the event I have an insurance and/or income change.

_____

Patient Signature **Date**

I give my consent to release my information to pharmaceutical companies for auditing purposes only in the bulk replacement patient assistance medication programs.

_____

Patient Signature **Date**

I understand that my health care providers and health benefit plans cannot refuse to treat me or deny me benefits simply because I refuse to sign this authorization.

_____

Patient Signature **Print Name** **Date**

_____

Person Signing on Behalf of Patient **Print Name** **Date**

_____

Witness Signature **Print Name** **Date**

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H-1 What is your housing situation today?
(a) I have housing.
(b) I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park); or
(c) I choose not to answer this question.

Source: PRAPARE, Q7

If (b) is selected (i.e., client is homeless) skip to H-4

H-2 Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?
(a) Yes
(b) No

H-3 Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?
(a) Yes
(b) No

Source: NC's SDOH Screening Tool

ONLY CLIENTS IDENTIFYING AS HOMELESS

H-4 Are any local agencies helping you find housing.
(a) Yes – Who?
(b) No

TRANSPORTATION

T-1 Has lack of transportation kept you from medical appointments, meetings, working or from getting things needed for daily living? *Check all that apply.*
(a) Yes, it has kept me from medical appointments or from getting my medications.
(b) Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need.
(c) No; or
(d) I choose not to answer this question.

Source: PRAPARE, Q15

FOOD

F-1 In the past year, have you ever used a Food Pantry/Soup Kitchen or received a food donation?
(a) Yes
(b) No

Source: Health Leads Social Needs Screening Toolkit

F-2 Within the past 12 months, did you worry that your food would run out before you got money to buy more?
(a) Yes
(b) No

Source: NC's SDOH Screening Tool

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F-3 Within the past 12 months, did the food you bought just not last, and you didn't have money to get more?
(a) Yes
(b) No

Source: NC's SDOH Screening Tool

EMPLOYMENT

E-1 What is your current work situation?
(a1) Unemployed-seeking work
(a2) Unemployed-not seeking work
(c) Full-time
(d) Part-time or temporary work
(e) Retired
(f) I choose not to answer

Source: PRAPARE, Q11

E-2 Do any of these apply. Select all that apply:
(a) Student
(b) Disability applied for
(c) Disability received
(d) Disabled, not eligible for benefits
(e) Primary caregiver
(f) I choose not to answer this question

INTERPERSONAL SAFETY

S-1 Do you feel physically and emotional safe where you currently live?
(a) Yes
(b) No

Source: NC's SDOH Screening Tool

S-2 Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?
(a) Yes
(b) No

Source: NC's SDOH Screening Tool

S-3 Within the last 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
(a) Yes
(b) No

Source: NC's SDOH Screening Tool

The applicant is considered to have "high unmet resource Need" if (a) they are homeless, (b) they screened positive for interpersonal safety (no to S-1 or yes to S-2 or S-3) or the client screened positive in 3 of the following areas: housing/utilities, transportation, food, or domestic violence.

Source: Using standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-Related Resource Needs in NC, NC Department of Health and Human Services, 4/5/18.