# Open Door Clinic

**Basic Access Application**

*Access to Primary Care Services*

The Open Door Clinic provides primary care and specialty care, with a focus on chronic illness management to those in our community who are...

- ✓ Adult
- ✓ Non-Pregnant
- ✓ Wake County Residents
- ✓ Uninsured *(have no health insurance/no access to health insurance)*
- ✓ Low income 200% FPL *(less than $4,300 a month for a family of 4)*

To establish care, please send this completed application, along with a copy of your Photo ID and proof of Wake County residency (recent utility bill, bank statement, etc). Send in your documents by:

**Email**: accesstocare@urbanmin.org **Fax**: 919-836-1352 **Mail**: 1390 Capital Blvd. Raleigh NC 27603

**Drop Off**: There is a secure drop off box at our office, to the right of our front glass doors, a black mail box.

Call 919-746-0098 once you have sent in your documents to schedule an appointment or if you have any questions.

**FULL Legal Name**: _____ **Date of Birth**: ___ / ___ / _____ **Gender** : MALE FEMALE

**SSN**: _____ [ x ] NONE **Citizenship Status**: ___ US CITIZEN ___ PERMANENT RESIDENT ___ FOREIGN CITIZEN W/VISA

**Tax ID**: _____ [ x ] NONE ___ ALIEN W/LEGAL EMPLOYMENT CARD ___ UNDOCUMENTED

**Marital Status**: ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ SEPARATED

**Race**: ___ WHITE/CAUCASIAN ___ BLACK/AFRICAN AMERICAN ___ ASIAN ___ PREFER NOT TO ANSWER

**Ethnicity:** ___ HISPANIC ___ NON-HISPANIC ___ PREFER NOT TO ANSWER

**Residential Address** *(patient MUST provide proof)*

Street: _____ Apt/Lot #: ____

City: _____ NC, Zip Code: _____

**Mailing Address** *(patient MUST provide proof)*

Street: _____ Apt/Lot #: ____

City: _____ NC, Zip Code: _____

**Patient Contact Information**

Cell: _____ Home: _____

Email: _____

**Emergency Contact** *(MUST be different telephone# from patient)*

Name: _____ Relationship: _____

Telephone: _____

I, _____, attest that there are ____ in my household and our
*(Patient name)* *(Total number of people in your household, this includes minors)*

estimated monthly gross income is $ _____ as of today, ____/ ____/ _____ .

# Acknowledgement of Open Door Clinic Policies and Procedures

- ✓ I understand that it is **my responsibility to notify the Access to Care department if/when I start receiving health insurance** either at work, through Medicaid or Medicare or through the healthcare marketplace. **Failure to do so may disqualify me permanently for services.** If I become eligible for Medicaid, Medicare or affordable medical health insurance through work and choose to opt out of receiving either, **I WILL NOT** be eligible for services at the Open Door Clinic. I understand services are available for those in our community that do not have access to health insurance.

1. **Accuracy of Information.** I understand that Urban Ministries of Wake County, Inc. is able to operate its Open Door Clinic due to generous contributions from concerned individuals, religious groups, businesses, and civic organizations. Services are available only for non-pregnant low-income Wake county residents who meet criteria guidelines. **I attest that the information that I have provided is correct**. I understand that I may need to provide documentation of income and other items**. I further understand that if any of my information changes- residence, income, insurance status- I must inform Open Door Clinic staff of those changes immediately**. If the information provided is NOT correct, or if I do not inform Urban Ministries of Wake County, Inc. of changes, I understand that I will not be allowed to receive services.
2. **Consent for Treatment. I hereby voluntarily consent to be examined and evaluated by the medical staff of the Open Door Clinic of Urban Ministries of Wake County, Inc., and to be tested and treated as deemed necessary and appropriate by them**. Among the services I receive, I may be tested for HIV/AIDS. I may decline this testing when offered. The staff will discuss the testing and treatment with me and answer my questions as fully as possible. I hereby give my consent to the Open Door Clinic health care provider to administer the vaccine(s) I have requested or that are ordered by the healthcare provider. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
3. **Child Safety.** I hereby acknowledge that medications received from Urban Ministries of Wake County, Inc. Open Door Clinic Pharmacy **may NOT be in childproof packaging, and I agree to use and store medication appropriately** to safeguard children.
4. **Clinic Standards and Code of Conduct.** I understand that I am forbidden to bring concealed weapons and any illegal substances into the Open Door Clinic. **I understand that acts that endanger the health and safety of me or others or which substantially interfere with the orderly operations of the facility will not be tolerated**. I understand that disrespect to any and all staff or other clients of the Open Door Client, **violence, threatened violence, or other illegal conduct towards any and all staff, volunteers or clients of the Open Door Client is not permitted** and will be recorded and handled according to the code of conduct procedures.
    - 1st offense: Verbal and written warning.
    - 2nd offense: Mandatory meeting with appropriate staff personnel.
    - 3rd offense: Patient will be deemed ineligible for services from the Open Door Clinic.
5. **Confidentiality.** I hereby authorize representatives Urban Ministries of Wake County, Inc. to request and/or release any and all information concerning my medical history, prescription record, applications for assistance, and such other information as may be needed to the most appropriate treatment plans. If I authorize another person or agency to request that Urban Ministries of Wake County, Inc. release my medical record to them, I understand that a record to prescriptions filled is included in the medical record. I may revoke this authorization at any time in writing; otherwise, this consent is valid for one year from the date signed and witnessed.

I acknowledge that I have thoroughly read the Open Door Clinic Policies and Procedures. My signature below acknowledges my understanding of and willingness to follow each of the stated policies.

Patient Signature: _____ Date: _____/ _____/ _____