MSU Care

Missouri State University | Mercy

640 E. Cherry Street, Suite 105
Springfield, MO 65806
Bus #12 on Cherry Street
Phone: (417) 837-2270
Fax: (417) 837-2271
www.msucare.org

Do you qualify?

MSU Care provides primary care services and prescription medications, free of charge, to individuals that are uninsured and are between the ages of 18 and 64.

Patient must be a US Citizen.

Patients cannot be eligible for and/or receiving Medicaid (MO HealthNet), Medicare, or any other health coverage

Patients must also meet income guidelines. Household, or family income, needs to equal or be less than 200% of the Federal Poverty Level

Household/Family Size	Annual Income 200%	Monthly Income
1	$27,180	$2,265
2	$36,620	$3,052
3	$46,060	$3,838
4	$55,500	$4,625
5	$64,940	$5,412

All applicants are to bring the items listed below to the Clinic to complete your enrollment packet:

- ✓ Current photo ID
- ✓ Two months of the most recent pay stubs for everyone in the household
- ✓ Most current year's federal income tax return for everyone in the household. (If taxes were not filed, MSU Care has a form to fill out.)
- ✓ Provide documentation of eligibility of federal, state, or other income benefit assistance including, but not limited to, SSI, SSD, VA, and/or Worker's Compensation for everyone in the household.
- ✓ Applicants may be asked to provide a recent Medicaid denial letter, verification of shelter, a signed letter of support, and/or letter of health insurance termination.
- ✓ Additional items may be required

MSU Care will not be able to schedule an appointment until **all** required items are received and enrollment packet is filled out.

MSU Care eligibility is in effect for 6 months, unless you obtain Medicaid (MO Healthnet), Medicare, or any other health coverage.

We are open Mondays, Tuesdays, Wednesdays, and Fridays 8 am-12 pm and 1 pm-5 pm. Thursdays are 10 am- 1 pm and 2 pm-7 pm. The lobby is closed for lunch and the clinic is closed on weekends.

If you have questions regarding the enrollment process, please call us at **(417) 837-2270** and a member of our team would be more than happy to assist you

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WELCOME TO MSU CARE

MSU Care is a collaboration between Missouri State University and Mercy Health Springfield Communities. Our goal is to provide high quality primary care to qualified uninsured adults, ages 18-64, and serve as your medical home. In addition, MSU Care will serve as a site for healthcare students and MSU faculty to be involved in clinical practice. Your care will be provided by nurse practitioners, physician assistants, physicians, and other members of the health care team. Our hope is that we can work together to: treat your short-term diseases, manage your chronic conditions, and help you stay healthy. We welcome you to MSU Care and thank you for choosing our clinic for your healthcare. The following includes information essential to your care.

PATIENT AGREEMENT

Rights and Responsibilities

As a partner in your healthcare, we will have responsibilities:

As your medical home, we will:

- Provide considerate and respectful quality care.
- Provide routine outpatient care at no cost to you in the clinic. However, certain medications or specialty care referrals may have a fee. You will be notified when a fee is involved prior to receiving care, and whether you qualify for Charity Care.
- Communicate information about your health in ways that you understand.
- Connect you with other members of your care team (specialists, educators, case managers), and coordinate your care with them.
- Help you make the best decisions for your care.
- Give you information about classes, support groups, or other resources/services that can help you learn more about your condition and what you can do to stay healthy.
- Notify you of test results in a timely manner.
- Provide care during the hours we are open. After that time, you will need to go to the ER for emergencies that cannot wait until the next day.
- Honor your right to refuse treatment.
- Honor your right to privacy and confidentiality.

As our patient, we trust that you will:

- Assume responsibility and take ownership for your own health and healthcare. Be encouraged to ask questions about your care.
- Provide us with accurate and current information and paperwork that we require to determine your eligibility for care and medications. Income verification is required every 6 months. This information is confidential and will not be released without your written permission or as required by law. Falsifying income or insurance information is grounds for termination of MSU Care services.

- Update your patient and eligibility information if there are any changes.

As our patient, we trust that you will (continued):

- Have the right to be treated with respect and dignity regardless of your race, religion, gender, ethnicity, sexual orientation, political affiliation, or disability.
- Be allowed to refuse treatment, as allowed by law, and to be told what might happen to you medically if this is your choice.
- Not sell or give your medications to others.
- Be open and honest about your health and health history, including alcohol and illegal drug use; your eligibility for care; and if you are seeing other doctors or taking medications we have not prescribed.
- Use the clinic as your primary health care source, and avoid using the Emergency Room unless you have an emergency (accident, severe bleeding, impaired consciousness, etc.) that cannot wait until the clinic opens the next day.
- Follow your treatment plan and take medications as prescribed, or tell us why you are not following and how we can help.
- Not bring illegal substances, drugs not prescribed to you, weapons, or alcohol into the clinic.
- Be courteous and respectful to all MSU Care clinic staff, providers, volunteers, and other patients.
- Give us feedback to help us improve our care for you.
- Understand that prescription refills and follow up care are your responsibility and should call MSU Care at least **two weeks** before you need a prescription refill. Refills are provided only at provider discretion.

NOTICES

Patients must acknowledge the following:

One of the goals of the MSU Care is to serve as a clinical site for healthcare professional students at MSU. These students are always under the supervision of a healthcare staff.

MSU Care is limited in the services they can provide on-site. MSU Care will provide what services they are capable of, but cannot provide all necessary healthcare and cannot treat all medical conditions. Therefore, any other medical services provided outside of the MSU Care clinic at Mercy, will be subjected to Mercy's Charity Care Policy. This would include, but is not limited to, specialty consultations, procedures, and professional fees related to clinic performed x-rays and EKGs. If services are referred or required outside of MSU Care, you may be responsible for the cost of the services and agree to hold MSU care, including all of its personnel and volunteers, harmless.

POLICIES AND PROCEDURES

Eligibility Documentation

The clinic will require that you submit the following documentation at the time of care. Failure to provide all of the documentation will cause you to have to reschedule your appointment to another day.

- ***Identification:***
  - current driver's license, state identification card, or other valid identification
- ***Income verification for all household income –***
  - Previous year's federal income tax return

- 4506T Form, if taxes were not filed
- Two months of most recent pay stubs for everyone living in the household
- Proof of eligibility of federal, state, or other income assistance including, but not limited to SSI, SSD, VA, Worker's Compensation, etc.
- A copy of a Medicaid Denial Letter

- ***Statement of Support***
  - If you do not have a household income, you will need to fill out a statement of support that shows how your needs are being met.

Keeping Scheduled Appointments

- MSU Care understands that situations may arise that do prevent you from keeping your appointment. Please be courteous to us and other patients by **calling at least 24 hours prior** to your appointment to cancel.
- Patients arriving more than 15 minutes late for their appointments will be counted as a **NO SHOW** and they will need to reschedule their appointments to another time and day. Come to your appointments on time or provide 24-hour notice, if possible, when cancelling appointments.
- If two appointments are missed within a 6-month period without notifying MSU Care in advance, you will no longer be able to receive services at MSU Care. We will continue serving you **only for the next 30 days** in case of urgency until you find a new provider.
  - Patient Initials: _____
- A missed referral appointment will be counted as a **NO SHOW**, and you may not receive any more referral appointments through MSU Care.

MSU Care Policies

- No alcohol or street drugs are allowed at the MSU Care site at any time. Guns and other types of weapons are not allowed at the clinic unless carried by a law enforcement officer or security personnel.
- No smoking will be permitted in the clinic, in the clinic entryway, or on the grounds of Missouri State University.
- Patients who are uncooperative, loud or disruptive in the waiting area, verbally or physically threatening/abusive, intoxicated, or behave in an inappropriate manner will be dismissed from the clinic and may no longer be eligible to obtain services from MSU Care. Depending on the severity of the incident, dismissal may be immediate and termination from the MSU Care may be final.
  - Patient Initials: _____
- Any minors (younger than 18 years) who come to the visit with the patient will need to stay with the patient during the exam and treatment.

INFORMATION DISCLOSURE

As a patient at MSU Care, I will authorize:

- Any health care professional associated with MSU Care to disclose any professional and/or personal health information to other health care professionals as may be necessary from time to time in connection with my health care.

- Any health administrative team member of MSU Care to disclose my registration and screening information for the purpose of obtaining no cost or low-cost medications, laboratory, or other health care services at Mercy or another facility.

CERTIFICATE OF NEED

As a patient of MSU Care, I certify that I have 1) NO health insurance including Medicaid, Medicare, Catastrophic, or High Deductible Insurance, and 2) meet the MSU Care definition of **uninsured and at or below 150% of the Federal Poverty Level.**

I also certify that I am honest and accurate about my health insurance and income status to the best of my knowledge. I understand that not telling the truth about my health insurance status hurts our entire community, and prevents other patients from being seen in a timely manner.

If my health insurance status changes and I find I am no longer eligible to receive services from MSU Care, I will either inform MSU Care or discontinue use of the clinic's services.

****

I, the undersigned, have read and understood the information listed above, and comply with the requirements of this **Patient Agreement.**

Patient Printed Name

Patient or Legal Guardian Signature

Date of Birth

Date

MSU Care

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Name: _____

Date of Birth: _____ MR#: _____ CSN#: _____

MSU Care Clinic Medication Donation Form
640 East Cherry Street Suite 105
Springfield, Missouri 65806
417-837-2270

Authorization for Donation of Unused Prescription Medication

I, _____, authorize the donation of unused prescription medication(s) **to MSU Care Clinic,** a non-profit 501c3 clinic. I understand that in executing this authorization and donating the unused prescription medication(s), I am consenting to participate in the Missouri Prescription Drug Repository Program, pursuant to 19 CSR 20-50.025.

I understand that the purpose of donating medication(s) through this program is to provide access to unused prescription drugs to persons in economic need. I understand that my participation is voluntary, and that my estate, or I shall not be subject to criminal prosecution, any professional disciplinary action, or as a claim of liability in any civil action.

I verify that the medication(s) being donated has been in the possession of the MSU Care Clinic licensed health care professionals as part of a medication patient assistance program, and that I am no longer taking the medication(s). The medication stored at MSU Care Clinic on behalf of the patient has been stored according to the manufacturer and/or *United States Pharmacopoeia* requirements.

Printed Name of Donor: _____

Signature of Donor: _____

Date: _____

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Name: _____

Date of Birth: _____ MR#: _____ CSN#: _____

The Prescription Drug Repository was created by the Missouri Legislature to provide access to unused prescription drugs for persons who have economic need.

Drugs that have been donated by individual patients may be provided by healthcare facilities such as nursing homes or hospitals to pharmacies, hospitals or non-profit clinics that agree to dispense the drugs to eligible recipients.

For safety reasons, donated drugs must have been under the control of a healthcare facility or healthcare professional, and cannot have been in the possession of the individual owner. The owner of the drugs is the patient for whom the drugs were prescribed and dispensed, regardless of the method of payment.

Participating dispensers may charge recipients a limited handling fee to cover stocking and dispensing costs. This handling fee may be no more than 200% of the standard Missouri Medicaid dispensing fee. The standard Missouri Medicaid dispensing fee is $4.09, so repository sites may charge no more than $8.18 per dispensing.

The program went into effect on January 1, 2005.

20 CSR 2220-2.013 Prescription Delivery Requirements

PURPOSE: This rule establishes requirements for authorized prescription delivery sites

(2) At the request of the patient or the patient's authorized designee, licensees may deliver a filled prescription for an individual patient directly to the patient or the patient's authorized designee or to—

(A) The office of a licensed health care practitioner authorized to prescribe medication in the state of Missouri;

(C) A hospital, office, clinic, or other medical institution that provides health care services;

Form **4506-T**
(November 2021)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b** First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	**2b** **Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / 31 /	/ /	/ /	/ /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____ _____
Signature (see instructions) | Date

▶ _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature | Date

COMMUNITY MEDICATION ACCESS PROGRAM (CMAP)

Mercy | JORDAN VALLEY COMMUNITY HEALTH CENTER | MSU Care — Missouri State | Mercy

AUTHORIZATION to REPRESENT

I, _____, directly or indirectly through the signature of my legal guardian or representative,
(Print Name)
hereby appoint the Community Medication Access Program (CMAP), its employees and agents to be my Authorized Representative for obtaining medications.

My Authorized Representative may:

- Execute Patient Assistance program applications on my behalf from the companies that make such medicines if I am participating in a Patient Assistance Program for such medications.
- Obtain information regarding my medical records, federal/state programs application status, employment status, income, and assets to substantiate my application(s).
- Pursue the appeal process in the event my application(s) is denied, if appropriate.
- Participate on my behalf and in my absence in any hearing or appeal.

The rights, powers, and authority of my Authorized Representative will remain in full force and effect until the conclusion of my application(s), when revoked in writing by me or my legal representative or when terminated by my Authorized Representative. I understand that I must revoke this Authorization to Represent in writing and that revocation of CMAP as my Authorized Representative is not effective until CMAP or any third party is notified of the revocation in writing. I attest that the information I have given in this enrollment application is accurate and true. I also understand that even if my application is approved, provision of medicines is not guaranteed. All applications are reviewed on a case-by-case basis. A copy of this Authorization to Represent shall have the same force and effect as the original.

Please note: when requesting assistance for Lantus, Apidra, Lovenox, and/or Multaq, Sanofi Patient Connection and its third party agents will use your date of birth or social security number and/or additional demographic information as needed to access your credit information and information derived from public and other sources to estimate your income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact your credit score.

(Check only one)

☐ I authorize CMAP program representatives to sign prescription assistance applications on my behalf.

☐ I *do not* authorize CMAP program representatives to sign prescription assistance applications on my behalf. I understand this will delay my receipt of medications by 2-3 weeks, but refusal to allow CMAP representative to sign forms on my behalf has no impact with respect to my enrollment in this program.

The undersigned certifies that I have reviewed the above provisions, had an opportunity to ask questions and that all of my questions have been answered to my satisfaction. The undersigned is the patient or is duly authorized to act on behalf of the patient to execute this Authorization to Represent and accept the terms hereof.

_____ _____ _____

Signature of Patient (or Legal Guardian/Representative) Date of Birth Date

COMMUNITY MEDICATION ACCESS PROGRAM (CMAP)

Mercy | JORDAN VALLEY COMMUNITY HEALTH CENTER | MSU Care Missouri State University | Mercy

Income Statement

Patient Name: _____ DOB: _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Employment Status: ☐Full-time ☐Part-time ☐Student ☐Self-Employed ☐Unemployed ☐Retired ☐Veteran ☐Legally Disabled ☐ NotLegally Disabled

Total number of people living in your home: _____; Number of Adults: _____, Number of Children _____

Income	Amount-You	Amount-Others in Household
Wages		
Retirement		
Social Security		
Social Security Disability		
Disability		
Unemployment		
Alimony		
Child Support		
Investments		
Other		
TOTAL		

Did you file Federal taxes last year?: ☐Yes – if yes, we need a copy ☐No

Proof of Income: (please send us a copy of all that apply **for each** person living in your home)

☐Complete Federal Tax Return
☐Veteran's Benefits Letter
☐Food Stamp Award Letter
☐Pension/Retirement Earning Statement
☐Unemployment Letter
☐1099 & W2
☐Social Security Award Letter
☐Social Security Disability Award Letter
☐Child Support Award Letter
☐Copy of Driver's License

MSU CARE Phone: (417)837-2270

COMMUNITY MEDICATION ACCESS PROGRAM (CMAP)

Mercy | JORDAN VALLEY COMMUNITY HEALTH CENTER | MSU Care — Missouri State University | Mercy

Self-Declaration of No Income

Please complete and sign this form if you have claimed zero or no income. Failure to complete this form will delay the processing of your medications. Leaving the form blank or writing N/A or dashes (---) is not acceptable.

Patient Name: _____ DOB: _____

Please explain how you have paid your monthly bills for the past 90 days:

If a non-household member is helping pay your bills, please list the name(s) and phone number(s) below.

First Name	Last Name	Daytime Telephone including Area Code
		( )
		( )

Please explain how you are paying the following monthly expenses:

Bill	Monthly Amount	If paid by someone else, it is a:	Bill	Monthly Amount	If pay by someone else, it is a:
Rent/Mortgage	$	☐gift ☐loan	Car Payment / Insurance	$	☐gift ☐loan
Food	$	☐gift ☐loan	Cable/Internet	$	☐gift ☐loan
Gas	$	☐gift ☐loan	Personal Expenses	$	☐gift ☐loan
Electric	$	☐gift ☐loan	Other _____	$	☐gift ☐loan
Phone/Cell	$	☐gift ☐loan	Other _____	$	☐gift ☐loan

I certify that the information contained above is true, complete and correct to the best of my knowledge. Inquiries may be made to verify statements herein. I understand that this agreement will last 1 year, at which time I will be required to either provide necessary documentation or renew this agreement.

_____ _____

Patient Signature Date

MSU CARE Phone: (417)837-2270

PHI Communication Form

IMPORTANT: This form does not give the authorized person(s) referenced below the permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record.

Patient Identification

Printed Name: _____ Address: _____

Date of Birth: _____ Last 4 digits of SSN: _____

_____ Telephone: _____

I, _____, hereby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below.

Authorized person(s) to receive **verbal** information regarding the above patient's care:

Printed Name	Relationship to Patient	Telephone
Printed Name	Relationship to Patient	Telephone
Printed Name	Relationship to Patient	Telephone

Mercy will not release paper or electronic copies of your medical record to anyone including those listed above unless an ***Authorization for Use and Disclosure of Protected Health Information or Patient's Request to Access Protected Health Information*** form is completed, or Mercy is already permitted by law to do so.

Mercy may still speak to other persons not listed on this form about your care if otherwise permitted by law.

I understand I may revoke this authorization at any time and Mercy will cease discussing my Protected Health Information with the above person(s) upon receipt, unless otherwise relied upon or if Mercy is not otherwise required by law to share information with the above person(s).

Patient or Legal Personal Representative: _____ Date: _____
Signature

Patient or Legal Personal Representative: _____
Printed Name

Authority of Personal Representative: _____

Patient Name:
MRN#:
Date of Birth:

Mercy

MSU Care Social Assessment

Last Name: _____ First Name: _____ Middle Initial: _____

DEMOGRAPHICS

Marital Status: ◯ Single ◯ Married ◯ Legally Separated ◯ Divorced ◯ Widowed ◯ Significant Other

Number of Children: _____

Education Level: ☐ GED ☐ High School ☐ Trade/Technical College ☐ Associate Degree ☐ Bachelor Degree ☐ Master Degree ☐ Doctoral Degree

GENERAL QUESTIONS

1. How confident are you filling out medical forms by yourself?

   ◯ Extremely ◯ Quite a Bit ◯ Somewhat ◯ A Little Bit ◯ Not At All

2. Do you ever have difficulty understanding the explanation, or instructions, you are given regarding your medical condition?

   ◯ Not at All ◯ A Little Bit ◯ Somewhat ◯ Quite a Bit ◯ Always

FINANCIAL RESOURCES

3. How hard is it for you to pay for the very basics like food, housing, and heating?

   ◯ Not Hard at All ◯ Not Very Hard ◯ Somewhat Hard ◯ Hard ◯ Very Hard

4. How long has it been since you've had regular access to the medications you need?

   ◯ Less than 3 Months ◯ 6 Months ◯ 9 Months ◯ 1 Year ◯ Longer than 1 Year

5. Within the last year, have you had any of your utilities turned off because you were unable to pay your bill?

   ◯ Yes ◯ No

FOOD INSECURITY

6. Within the past 12 months, have you worried that your food would run out before you got money to buy more?

   ◯ Never True ◯ Sometimes True ◯ Often True

7. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

◯ Never True ◯ Sometimes True ◯ Often True

TRANSPORTATION

8. In the past 12 months, has a lack of transportation kept you from medical appointments or from getting medications?

◯ Yes ◯ No

RESOURCES

9. Do you need resources for dental care?

◯ Yes ◯ No

10. Do you need resources for an eye exam?

◯ Yes ◯ No

11. Do you have any needs regarding the following items:

☐ Hygiene Items ☐ Summer Clothing ☐ Winter Clothing ☐ Socks
☐ Blankets ☐ Back Pack ☐ Water Bottle ☐ Umbrella/Poncho

Other: _____

12. Do you have a case manager?

◯ Yes ◯ No

If yes, please provide us with their contact information:

Name: _____ Phone Number: _____

13. Is there anything else that is important that we need to know?

_____

_____

Was this assessment completed by the patient?

◯ Yes ◯ No

If no, please provide us with the name and role of the individual who did.

Name: _____ Role: _____