Dear Applicant,

CARE RING
THE HEART OF COMMUNITY HEALTH

Thank you for your interest in Physicians Reach Out (PRO). PRO is a Care Ring non-profit program that provides access to medical care to qualified uninsured residents of Mecklenburg County. Physicians Reach out is not health insurance.

In order to qualify and enroll in Physicians Reach Out all applicants must meet the eligibility requirements listed below. Please schedule an eligibility interview and complete this application. A $30 non-refundable application fee per household will be due at your interview. Physicians Reach Out accepts cash or money order only. Please be aware that there is also a 25 cent fee per page for copies of documentation.

You may call 704-375-0172 to schedule, reschedule, or cancel your eligibility interview.

Eligibility Criteria:

1. Applicants must be a Mecklenburg County Residents (minimum of 3 months)
2. Applicants cannot have health insurance through an employer, spouse's employer, school, Medicaid, Medicare, worker's compensation, veteran benefits, or the Health Insurance Marketplace (Obamacare).
3. Household Income must be within 200% of the Federal Poverty Level. The full chart is available at www.careringnc.org

Please provide **copies** of all documentation below if it applies to your household.

1. Complete this application and sign where indicated.
2. Proof of Identity: state ID or government issued photo ID **and** Social Security Card.
3. Proof of Citizenship: Birth Certificate, US passport, Voter Registration Card, Permanent Resident Card, or Employment Authorization Card.
4. Proof of Residency: state ID, lease, utility bill, or medical bill with current address.
5. Proof of Household Income. Please include for all household members.
    a. Working (both items below required, if applicable):
        i. One months' worth of consecutive pay stubs dated within the last 60 days
        ii. Provide a letter for each employed applicant from their employer stating whether or not the applicant is enrolled in the company Health Insurance (page 5).
    b. Self-employed (both items required, if applicable):
        i. Profit and Loss Chart (consecutive 3 months business income and expense information in chart format attached to the application on page 6) with receipts, copies of checks, etc. attached to document business transactions.
        ii. All business and personal bank statements for the 3 months that correspond with the chart created above.
    c. If you are receiving Retirement, Pension, Worker's Compensation, Child Support, Alimony, or VA benefits provide a recent statement outlining monthly benefits received.
    d. If you are receiving Social Security, Supplemental Social Security, or Disability income provide the benefit letter from the current year.
    e. If you are receiving unemployment benefits provide the benefit awards letter or an official 30 day payment record.
6. If a person or group is providing financial support or room and board please have them fill out the Letter of Support on page 4.

Applications will be reviewed at your eligibility interview. To schedule an eligibility interview, or if you need assistance completing your application, please call 704-375-0172.

601 E. 5th Street, Suite 150, Charlotte, NC 28202**, phone: 704-375-0172, fax: 704-943-3747**, www.careringnc.org

Physicians Reach Out Enrollment Application

First Name:	MI:	Last Name:	Birth Date:	Gender: □ Male □ Female
Social Security Number:	Home Phone #:	Cell Phone #:	Email Address:	
Mailing Address:	City:	State:	Zip Code:	
Physical Address *(if different from Mailing Address):*	City:	State:	Zip Code:	
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Other	Language Spoken at Home: _____ Interpreter needed? □ Yes □ No	Number of people in your household: _____		
Applicant's Family Doctor or other Healthcare Providers: _____	Race/ Ethnicity: □ Asian □ Black □ Hispanic □ White □ Other _____			
Emergency Contact Name:	Contact Phone Number:	Relationship:		

List all Household Income, monthly gross amount only:

Salary/Wages	$_____
Social/Supplemental Security	$_____
Retirement/Pension	$_____
Unemployment Benefits	$_____
Disability	$_____
Child Support/Alimony/TANF	$_____
Other_____	$_____
Total Gross Monthly Income	$_____

*** Proof of all income required***

Please indicate below if any applicants have one of the types of insurance below:

Health Insurance	□ Yes □ No
Medicaid	□ Yes □ No
Medicare	□ Yes □ No
Worker's Compensation	□ Yes □ No
Marketplace Insurance (*Obamacare*)	□ Yes □ No

*** PRO may request proof that an applicant does not have one or more of these types of insurance at any time during the application process or enrollment period***

Please make sure you have provided the best contact information in this application. If you move or if any of your contact information changes please update PRO immediately. The nurse case manager, social worker, and access coordinators may need to contact you with important information regarding your health, appointments, or enrollment in PRO.

Household Demographics

Please list ALL household members regardless of age or relationship to you.

Last Name	First Name	Relationship to you	Date of Birth (required)	Gender (Male or Female)	Marital Status	Social Security Number	Applying to PRO?
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No
							□ Yes □ No

Everything I have stated in this application is correct to the best of my knowledge. I understand that this application and the supporting documentation I have provided is required to enroll in Physicians Reach Out (PRO) and I authorize PRO to check employment history or any other information requested in this application.
If I have provided false, misleading, or incomplete information, I will not be eligible for services through PRO. By signing this form, I authorize the use of my social security number and my dependents' social security numbers for the purpose of verifying information.

Patient/Guardian's Signature: _____ Date: _____

CARE RING
THE HEART OF COMMUNITY HEALTH

LETTER OF SUPPORT

I _____ am providing support for
(Person providing support)

_____ in the following way.
(Physicians Reach Out applicant)

Check **one** of the boxes below:

- ☐ Lives with me at the address below and receives room and board in the *value* indicated below.
- ☐ Does not live with me but I provide support as indicated below

I provide support *for the applicant only* in the approximate amounts indicated below. Enter the approximate dollar value for each item. If you do not provide support for a particular item, enter $0.

Food:	$ _____	Monthly
Housing:	$ _____	Monthly
Utilities:	$ _____	Monthly
Cash:	$ _____	Monthly
Other:	$ _____	Monthly

_____ _____
Signature (Person Providing Support) Date

_____ _____
Print name (Person Providing Support) Relationship to applicant

_____
Print your Street Address, City, State and Zip Code

Health Insurance Information Form

To be completed by the employer only

CARE RING
THE HEART OF COMMUNITY HEALTH

To whom it may concern,

Physicians Reach Out is a non-profit charity care program committed to providing access to primary and specialty care for the uninsured in Mecklenburg County.

_____ is applying to Physicians Reach Out. In order for them to qualify they must not be enrolled in a health insurance plan through their employer (or their spouse's employer, if applicable). Please check the appropriate box below to indicate their current insurance status:

- ☐ The employee named above is currently enrolled in a company offered health insurance plan.
- ☐ A family member of the employee named above is currently enrolled in a company offered health insurance plan.
  - Please list all family members currently enrolled:

    _____
- ☐ Both the employee named above and their family members are **not** enrolled in any company offered health insurance plans.

_____ _____

Signed (Manager, Supervisor, or Human Resources Dept. only) Date

_____ _____

Please Print Name Phone Number

This information will only be used for enrollment in a local Charity Care program to provide access to care for the uninsured. We thank you for your time and assistance today.

Sincerely,

The Access Coordinators at Care Ring Physicians Reach Out
Phone: 704-375-0172
Fax: 704-943-3747
Address: 601 E. 5th Street, Charlotte, NC 28202
Website: www.CareRingNC.org

Profit and Loss Statement- Self Employed Only
(Examples: Cab Drivers, Hair Stylists, Nannies, Housekeepers, etc.)

Month_____	Month_____	Month_____
Total Gross Income	Total Gross Income	Total Gross Income
Expenses: Total Expenses:	Expenses: Total Expenses:	Expenses: Total Expenses:
Net Income:	Net Income:	Net Income:

Please list the monthly expenses related to your business, including the dollar amount. (For example: Supplies, Rent, Repairs, etc.). Please provide 3 months' worth of copies of receipts for corresponding expenses.

You must provide copies of 3 months' worth of invoices and/or receipts for proof of income.

You must provide copies of 3 months' worth of complete bank statements for business.

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

_____ _____

(Signature of applicant) (Date)