CARE RING
THE HEART OF COMMUNITY HEALTH

NEW REVIEW PROCEDURE

YOU MAY MAIL OR DROP OFF YOUR RENEWAL PACKET AT OUR OFFICE

1. **One application per family is required. (Mother, father, and children under 18 years of age)**
2. **A non-refundable renewal fee is required. Please enclose a MONEY ORDER ONLY (NO CHECKS ACCEPTED) for $20 per family, made payable to: Care Ring. You may also drop off the renewal packet with a $20 CASH or Money Order payment.**
3. Complete the enclosed application and read and sign all enclosed forms.
4. From the list on page 2, send copies of the documentation that **applies to your situation**.
5. Mail or drop off the application, forms, payment and copies of your documents to Physicians Reach Out.
6. **Due date**: It must be postmarked by_____.

****DO NOT SEND CASH IN THE MAIL****

Our office is located at:
601 E. 5th Street Suite 150
Charlotte, NC 28202
704-375-0172
www.careringnc.org

Win a $25 Walmart gift card!

Return your completed renewal application, payment, and supporting documents by the due date and be entered to win a $25 Walmart gift card.

We will notify the winner.

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REQUIRED INCOME DOCUMENTATION

The following documents must be attached to all applications **without exception**. **Originals will not be accepted**. **COPIES MUST BE PROVIDED**. Documents will not be returned.

- **Proof of US Citizenship or Resident Alien Status((US passport, birth certificate, US voter card, certificate of naturalization, permanent resident card, etc)**

- **Most current Bank Statement for you and/or your spouse (Checking and Savings Acct)**

- **Letter of Support *with total monthly value for room and board***

- **Two (2) recent and consecutive pay stubs for EACH wage earner and for EACH job: full, part-time, temp, seasonal or free-lance jobs. Must show gross and net income**
  - If pay stubs are not available, provide letter of employment specifying gross salary, signed and dated by employer on company letterhead
  - If doing odd jobs, a written statement from the household members of average earnings per month.
  - Own Business/Self-Employee: List detail of Income and Expenses for 3 consecutives months.

- **Documentation of following benefits:**
  - Social Security, unemployment, disability, retirement, pension, Welfare, Food Stamps/EBT, Section 8, HUD, Housing Assistance, TANF (Temporary Assistance to Needy Families), Workman's Compensation, Child Support.

- **Tax Return**
  - Current year Income Tax Return, Form 1040 or 1040EZ, as filed with the Internal Revenue Service (IRS). IRS can be contacted at 1-800-829-1040

IF THERE ARE ANY QUESTIONS, PRO WILL CONTACT YOU

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RENEWAL

Last Name	First Name	MI	SSN
	Birth Date: **mm/dd/yyyy**	Age	Gender ☐ Female ☐ Male / Race
Street Address		P. O. Box (*mailing only*)	
City	State	Zip Code	
Home Phone	Alternative Phone	Cell Phone	Work Phone
Applicant's Primary Care Physician		Applicant's Specialist	
Spouse's Primary Care Physician		Spouse's Specialist	
Children's Primary Care Physician		Children's Specialist	
Emergency Contact Name	Relationship	Phone Number	
Language	Need Interpreter? ☐ Yes ☐ No		
Housing: ☐ Own ☐ Rent ☐ Community Shelter ☐ Staying with Family/Friends ☐ Homeless	Lived in Mecklenburg for: _____yrs. _____ months		
Household Name *(Please leave in blank)*	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Civil Union	Family Size	

List Family Members *(Only spouse and children under 18 years of age)*

Last Name	First Name	Relationship	DOB **mm/dd/yyyy**	Sex F/M	Marital Status	Race	SS # or W-7	Applying for this person?
1.			/ /					☐ Yes ☐ No
2.			/ /					☐ Yes ☐ No
3.			/ /					☐ Yes ☐ No
4.			/ /					☐ Yes ☐ No
5.			/ /					☐ Yes ☐ No
6.			/ /					☐ Yes ☐ No
7.			/ /					☐ Yes ☐ No
8.			/ /					☐ Yes ☐ No

EXPENSES (Monthly) **Please write dollar amount of expenses**	
Rent/Mortgage	$
Water	$
Gas/Electricity	$
Telephone	$
Cable/Direct TV/Dish	$
Internet	$
Vehicle Payment (monthly)	$
Vehicle Insurance (monthly)	$
Food (If receiving food stamps write amount)	$
Gasoline	$
Child Support (paying)	
Property Taxes (break it down in 12)	$
House insurance (break it down in 12)	
Total Monthly Expenses	$

_____ _____

Applicant's Signature ***Spouse's Signature***

Date: _____/_____/_____

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HEALTH INSURANCE INFORMATION REQUEST

To be completed by Employer Only

Please answer the following questions regarding the employee:

Employee Name: _____

1. Is ***HEALTH INSURANCE*** currently available for his/her purchase through the company?
   ☐ **Yes** ☐ **No**

   If the answer is NO, will he/she be eligible on a future date? ☐***Yes*** ☐***No***
   On What Date? _____/_____/_____

2. If the health insurance is available currently *or* in the future, is it also available for purchase for his/her family members? ☐ **Yes** ☐ **No**

3. When is Open Enrollment Season for health insurance through the company? ____ /_____ /_____

4. If employee chooses to enroll in the insurance plan through the company, what date will the insurance take effect? ? ____ /_____ /_____

5. How much would the Monthly Premium be?

   Individual $ _____ **Family $** _____

6. How much would the Deductible be?

   Individual $ _____ **Family $** _____

PLEASE ATTACH THE SUMMARY OF BENEFITS FOR EACH PLAN

Date: _____/_____/_____

Manager's Name _____

Manager's Signature: _____

Please Remember to Attach Your Business Card or Business Stamp!!

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INFORMACIÓN DE SEGURO DE SALUD

Para completar únicamente por Empleador

Por favor responder las siguientes preguntas en referencia a su empleado

***Nombre de Empleado**:* _____

1. ¿Es actualmente ofrecido ***SEGURO DE SALUD*** para su empleado(a) a través de su compañía? ☐**Sí** ☐ **No**

   Si la pregunta es NO, será elegible en una fecha futura? ☐***Sí*** ☐***No***
   En qué día? _____/_____/_____

2. Si el Seguro de Salud es disponible actualmente *o* en un futuro, es disponible para el resto de los miembros de la familia? ☐ **Sí** ☐ **No**

3. ¿Cuando es la fecha de Apertura para la Inscripción? ____ /_____ /_____

4. Si el empleado decide inscribirse en el Plan de Salud, ¿Cuándo sería efectivo el mismo?____ /_____ /_____

5. ¿Cuánto sería el valor Mensual del Premium?

   Individual $ _____ **Familiar $** _____

6. ¿Cuánto sería el valor del Deducible?

   Individual $ _____ **Familiar $** _____

POR FAVOR ADJUNTE EL SUMARIO DE BENEFICIOS POR CADA PLAN

Día: _____/_____/_____

Nombre del Manager _____

Firma del Manager: _____

Por favor Recuerde Adjuntar su Tarjeta de Presentación o Estampilla del Negocio

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LETTER OF SUPPORT

Date: _____

I, _____ (name of person providing support), pay rent and utilities on behalf of *or* for _____ (person being supported). I am not financially responsible for his /her bills or able to buy his /her medications. I provide room and board in the amount of $ _____ per month (dollar value of support).

_____
Signature

_____
Printed Name

_____
Address

_____
Phone Number

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CARTA DE SOPORTE

Fecha: _____

Yo, _____ (nombre de la persona que le brinda el apoyo) certifico que pago la renta y servicios (electricidad, teléfono, agua) a favor de _____ (nombre de la persona beneficiada). A la vez aclaro que no soy responsable financieramente del pago de sus deudas ni estoy en condiciones de suministrarle sus medicinas. Yo le proveo vivienda y/o comida por el valor de $_____ al mes (valor del apoyo).

_____
Firma

_____
Nombre y Apellido

_____
Dirección

_____
Teléfono

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Please take a few minutes to complete the following satisfaction survey. Your feedback about our program is greatly appreciated.

1. How did you hear about Physicians Reach Out?
   - □ Department of Social Services
   - □ Sliding scale / free clinic
     Clinic Name: _____
   - □ My Doctor / Nurse
     Doctor / Nurse's Name: _____
   - □ Relative or friend
   - □ Other, please explain: _____

2. How long have you been a member of the Physicians Reach Out program?
   - □ 0 – 6 months
   - □ 6 – 12 months
   - □ 1 – 2 years
   - □ 2 – 4 years

3. Would you refer a friend or family members to the Physicians Reach Out program?
   - □ Yes
   - □ No
     If no, why not? _____

4. If Physicians Reach Out was unavailable to you, what would you do for healthcare?
   - □ Use the Emergency Room to see a physician, with or without paying for services
   - □ Make payment arrangements with my current doctor
   - □ Nothing. My resources are limited for receiving health care without the Physicians Reach Out program

5. How do you fill the prescriptions that you receive from your physician? (Mark as many as apply.)
   - □ MedAssist
   - □ Local Pharmacy
     Name of Pharmacy: _____
   - □ I do not get my prescriptions filled
   - □ Other: _____

6. If you do NOT get your prescriptions filled, why not?
   - □ Not enough money
   - □ I do not know where to go
   - □ MedAssist is a difficult program to join
   - □ I do not really need prescriptions

Please see page -2- >>>

The following are statements. Please specify how much you agree or disagree with the statement. Circling a “5” indicates that you agree completely.

7. Applying for PRO was an easy process.	1 ☹ ☺	2	3 😐	4	5
8. Renewing for PRO is an easy process.	1 ☹ ☺	2	3 😐	4	5
9. The PRO staff is friendly and helpful.	1 ☹ ☺	2	3 😐	4	5
10. I feel at ease around the PRO staff.	1 ☹ ☺	2	3 😐	4	5
11. Getting in touch with the PRO staff is fairly easy.	1 ☹ ☺	2	3 😐	4	5
12. My assigned primary care physician treats me with respect.	1 ☹ ☺	2	3 😐	4	5
13. My primary care physician’s staff treats me with respect.	1 ☹ ☺	2	3 😐	4	5
14. My primary care physician’s staff is knowledgeable about the program.	1 ☹ ☺	2	3 😐	4	5
15. My assigned specialists treat me with respect. (If you are being seen by one)	1 ☹ ☺	2	3 😐	4	5
16. I feel comfortable around the physicians that participate in PRO.	1 ☹ ☺	2	3 😐	4	5
17. I have received the specialty care that I need.	1 ☹ ☺	2	3 😐	4	5
18. Getting the medication I need is easy and inexpensive.	1 ☹ ☺	2	3 😐	4	5

Please feel free to make additional comments below. Thank you for your time.