HEART SOUL FREE CLINIC

Where Healing Meets Hope

Patient Demographic Form

Thank you so much for visiting the Heart and Soul Free Clinic! Your answers to the following questions aids us in securing the grant funding that allows us to provide free medical and dental care. All of your answers will be kept strictly anonymous, so please answer as accurately as possible. For the purpose of this form, the term household is defined as all the persons who occupy a housing unit as their usual place of residence. A housing unit is a house, an apartment, a mobile home, a group of rooms, or a single room that is occupied (or if vacant, is intended for occupancy) as separate living quarters.

Today's Date _____ / _____ / _____

Patient Name: _____ Age of **Patient**: _____ years old **Patient's** Zip code: _____

Patient's Gender: FEMALE MALE OTHER:_____

1) In the last year, has the **patient** struggled to secure immediate and or affordable mental health care? YES NO

2) Is there an individual in the **patient's** household who is disabled or handicapped? YES NO

Is the **patient** being seen disabled? YES NO

3) Does the **patient** work: FULL-TIME PART-TIME UNEMPLOYED DOES NOT APPLY

4) Does a lack of transportation hinder the **patient** from: OBTAINING FOOD RECEIVING MEDICAL CARE WORKING

5) **Patient's** current housing situation: RENT OWN DOES NOT HAVE HOUSING OTHER:_____

6) In the last 6 months, has the **patient** been unable to pay for or obtain food? YES NO

7) In the last 6 months, has the **patient** been unable to pay their utilities? YES NO DOES NOT APPLY

8) Has the **patient** being seen received assistance from their township trustee in the last 12 months? YES NO

9) Has the **patient** been released from incarceration in the last 90 days? YES NO

10) Does the **patient** smoke? YES NO

If yes, would the **patient** like to receive information about the Indiana Smoking Cessation Program? YES NO

11) In the last 6 months, has the **patient** experienced any concerns with drugs or alcohol? YES NO

12) What is the **patient's** primary language (i.e. English, Spanish, Arabic, Mandarin)? _____

13) Does the **patient** require an interpreter? YES NO

14) Does the **patient** being seen have medical insurance? YES NO

If yes, what type? (i.e Medicare, Medicaid, Employer): _____

15) Does the **patient** being seen have a Primary Care Physician? YES NO

16) Does the **patient** being seen have dental insurance? YES NO

If yes, what type? (i.e Medicare, Medicaid, Employer): _____

Please Turn Page to the Other Side

17) **On the Table Below:**

1) Please circle the number of individuals in the **patient's** household.
2) Please circle the **patient's** total annual household income corresponding with the number of individuals in the **patient's** household.

1	0 - $16,250	$16,251 - $27,050	$27,051 – $43,250	More than $43,250
2	0 - $18,550	$18,551 - $30,900	$30,901 - $49,400	More than $49,400
3	0 - $20,850	$20,851 - $34,750	$34,751 - $55,600	More than $55,600
4	0 - $25,100	$25,101 - $38,600	$38,601 - $61,750	More than $61,750
5	0 - $29,420	$29,421 - $41,700	$41,701 - $66,700	More than $66,700
6	0 - $33,740	$33,741 - $44,800	$44,801 - $71,650	More than $71,650
7	0 - $38,060	$38,061 - $47,900	$47,901 - $76,600	More than $76,600
8	0 - $42,380	$42,381 - $51,000	$51,001 - $81,550	More than $81,550

18) Number of persons in **patient's** household: ADULT(S) _____ CHILDREN _____

19) How does the **patient** identify? (Circle All That Apply)

American Indian or Alaska Native
Asian
Black or African American
Arabic
Native Hawaiian or Other Pacific Islander
White
Hispanic
Other: _____

20) **Patient's** marital status: MARRIED SINGLE WIDOW/WIDOWER

21) Does the **patient** reside in a single parent household? YES NO

If yes, Is the single parent FEMALE MALE OTHER

22) **Patient's** Level of Education (Please Circle One)

Current Student (Under 18 years old)
School Attending:_____
Current Student (Over 18 years old)
School Attending:_____
Some School (No Diploma)
High School Graduate/GED
Some College
College Graduate

23) Does the **patient** being seen receive any of the following? (Circle All That Apply)

Food Stamps
WIC
Public Housing/Section 8
Medical Assistance
Temporary Assistance to Needy Families (TANF)
Supplemental Security Income (SSI)
Children's Health Insurance Program (CHIP)
Qualified Medicare Beneficiary

24) How did the **patient** hear about Heart and Soul? (i.e. Friend, Family, Grace Care Center, Trinity Free Clinic, Hope Clinic)?

_____

Appendix C
FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Sample Patient Notice of Limited Liability of FTCA Deemed Volunteer Free Clinic Health Care Professionals

Notice to Patients

To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as its practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(B), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by an free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (I.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997, may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

Acknowledged:

_____
(Patient Signature)

_____
(Patient name, printed legibly)

_____
Date

Proposed Project: Free Clinic FTCA Deeming Application (OMB No. 0915-0293) Revision

HEART SOUL FREE CLINIC
Where Healing Meets Hope

HEART AND SOUL REGISTRATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Cell phone#: ( )	Home phone #: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

You may **release** medical information to the following:

Name	Relationship	Phone

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

Patient Signature **(parent signature if patient is under 18 years old)** Date

4/7/2016

Medical History

Patient Name: Birth Date: Date:

Are you under a physician's care now? Yes No If yes _____

Have you ever been hospitalized or had a major operation Yes No If yes _____

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Are you allergic to any of the following? (circle all that apply)

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/IntestinalDisease	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
									Yellow jaundice	Yes	No

Have you ever had any serious illness not listed Yes No If yes_____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health.

Signature of Patient, Parent or Guardian:

X_____ Date: _____

HEART AND SOUL CLINIC, INC.
P.O. Box 478
Westfield, IN 46074

RELEASE OF INFORMATION

(English)

For and in consideration of the medical treatment and/or consultation made available to me without charge at Heart and Soul Clinic, Inc., I hereby agree to the following terms:

I hereby grant Heart and Soul Clinic, Inc. full and unrestricted access to all of my health records, regardless of their location and/or of whose custody the health records are currently in.

I hereby release, relieve and discharge from liability Heart and Soul Clinic, Inc., its officers, directors, agents employees, and volunteers of and from all liability for any and all losses, injuries, or damages to either my person or to my property, occasioned by, in any manner growing out of, or as a direct or indirect result of my receipt of any diagnosis, consultation, procedures, medications, treatments or advise or by anyone providing any such diagnosis, consultation, procedures, medications, treatment or advise in which the Heart and Soul Clinic, Inc. has any responsibility or its made available by it.

I hereby give my permission to the Heart and Soul Clinic, Inc. its agents and volunteers to treat me during this clinic visit and all subsequent visits and to provide drugs, medical care and other services and supplies as are needed for my health and well-being. I acknowledge that no representations, warranties or guarantees as to results or cures have been made to me by Heart and Soul Clinic, Inc., or its agents, nor have I relied upon any such representations, warranties or guarantees.

I hereby give my permission for the Heart and Soul Clinic, Inc., to pursue other health professionals in consultation/referral regarding my medical condition for the purpose of continuity of health care. I am aware that the Heart and Soul Clinic, Inc., cannot guarantee the care provided by a referring physician or health care specialist will be rendered free of charge to me and that the Heart and Soul Clinic, Inc., cannot assume responsibility for payment.

By my signature below, I certify that I have read this ***Release of Information*** (or have had the same read to me) and that I fully understand its provisions I now voluntarily sign the ***Release*** as evidence of my intent and agreement to be bound by it.

----------***(Spanish ~ Espanol)***----------

En consideracion a la consulta y al tratamiento medico que gratuitamente he reeibido por parate de la clinica, Heart and Soul Clinic, Inc., por este conducto doy me consentimiento a los siguientes terminus:

Doy mi consentimiento para que Heart and Soul Clinic, Inc., tenga acceso sin restriccion alhuna a mis expedients medicos, sin importer el lugar y/o la custodia donde se encuentren actualmente.

Libero de toda responsabilidad o cargo de demanda a la clinica, Heart and Soul Clinic, Inc., a sus oficiales, directores, agents, resultado de, o directa o indirectamente como resultado del diagnostico, consulta, procedimientos, medicamentos, tratamientos o consejo en los cuales la clinica, Heart and Soul Clinic, Inc., tenga responsabilidad alguna o este involucrate en la disponibilidad de dichos servicios.

Por medio de este documento, doy mi consentimiento a la clinica, Heart and Soul Clinic, Inc., sus agenies y voluntarios para que me dentratamiento durante mi visita a la clinica y todas las visitas subsequentes, asi comom para recetarme medicamentos, darme cuidados medicos y otros servicios y materiales, segun sea necesario para mi salud y mi bienestar. Reconozco que, ni Heart and Soul Clinic, Inc., ni sus volungarios me han ofrecido nongun tipo de esa garantias.

Por medio de este documento, doy mi consentimiento a la clinica, Heart and Soul Clinic, Inc., para consultar con ostros medicos profesionales respecto a mi condicion medica con el proposito de continuar con mis cuidandos de salud. Estoy consciente de que la clinica Heart and Soul Clinic, Inc., no so hara responsible por pagos que se puedan adeudar a dichos especialista.

Por medio de mi firms en este documento, certifleo que he tenido la oportunidad de leer este consentimiento (o que el mismo me has sideo leido por una tercera persona) y ratifico que comprndo en su totalidad su contenido. A continuacion firmu voluntariamente este consentimiento como evidencia de me acuerdo a lo aqua antes estipulado.

_____ _____

Printed Name/Nombre del paciente impreso Date/Feche

_____

Patient Signature/Firma del paciente

_____ _____

Patient Representative/Reprosentante del pacient Relationship/Relacion con el pacente

HS006 4/7/2016