



## **Greater Hickory Cooperative Christian Ministry General Client Waiver**

As a client of Greater Hickory Cooperative Christian Ministry (GHCCM), I acknowledge, understand, and accept the following information and guidelines.

- GHCCM is a private non-profit organization and receives limited county, state and/or federal dollars to support our work.
- GHCCM will do whatever we can, whenever we can to help (provided your eligibility is current), but clients are not guaranteed or entitled to any specific services.
- I understand that much of my care is provided through the work of volunteers, therefore I hold GHCCM harmless for services provided in good faith.
- I understand that HealthCare services should be obtained by calling for an appointment. Walk ins are welcome and services are provided on a first-come, first-serve basis.
- I understand that at times GHCCM will be unable to provide a service that is recommended and it will be my responsibility for any needed services.
- I understand that any and all charges for services provided outside GHCCM (if any) is my responsibility.
- I accept responsibility for the fact that all medications (such as samples) may not be packaged in child safety containers and that I am responsible when they are dispensed to me. I will store them out of the reach of small children.
- I understand that it is my responsibility to keep GHCCM informed of any changes in my address, phone number, income, expenses, and insurance status and that all information provided is accurate and complete to the best of my knowledge, I understand that I am subject to dismissal if found to be otherwise.
- I understand that GHCCM has a "NO TOLERANCE" policy toward abusive behavior and vulgar language in the facility and on the grounds property.
- I understand my services can be terminated if I engage in any of these activities on GHCCM property.
- I attest that the information on this application is true and accurate to the best of my knowledge.

Clients Initials: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Interviewers Initials: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

## Authorization to Release and Retrieve Information

As a client of Greater Hickory Cooperative Christian Ministry/MACC, I grant permission for the following:

- ▶ As a HealthCare client I authorize release of information (including, but not limited to: name, diagnosis, and financial information) to the pharmaceutical companies for the purpose of receiving medications on my behalf as well as providing necessary information for audit purposes.
- ▶ To release needed information by phone/CRIS/MACC/CHIN to other providers or agencies in an effort to network and provide services on my behalf.
- ▶ I understand that medical records will not be copied and released or retrieved without my expressed permission.
- ▶ I understand that I have the right to refuse release of such information upon request, but in doing so, I understand that this may also limit the resources/services available to me.
- ▶ I grant permission for **Social Services to release income and household information to GHCCM** for the purpose of obtaining services.
- ▶ I understand that any financial payments used to assist my case with HPRP funding will be made from Mental Health Partners.

Client's Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Interviewer's Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

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## Limited Power of Attorney For The Patient Assistance Program

As a patient of Greater Hickory Cooperative Christian Ministry's Clinic and Pharmacy, you are probably receiving some of your medications through the pharmaceutical manufacturer's Patient Assistance Program. The drug manufacturer has the right to view all of the client record information upon all requests as required by program business rules. The form that we are required to send to the manufacturer requires a patient's signature. If you agree to allow GHCCM to sign these forms on your behalf, please complete and sign the information below.

I \_\_\_\_\_ give my permission to GHCCM to obtain medications from  
(Please print name)  
pharmaceutical manufacturer's Patient Assistance Programs.

Client's Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Interviewer's/Witness Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

## NOTICE ON THE USE OF SOCIAL SECURITY NUMBERS

(This is not an application)

If members of your family or household want to receive Food Assistance, Medicaid, Special Assistance or Work First Family Assistance benefits, they must provide Social Security Numbers. Only those who provide or apply for a SSN will receive benefits if otherwise eligible. Applications for Food Stamps and Work First Family Assistance benefits will not be delayed or denied if an individual in your family or household does not provide his or her Social Security Number. These family or household members may be required to answer other questions on the application related to the family's financial circumstances. This notice only applies to social security numbers.

- Any individual in your household who wants to receive assistance must furnish all social security numbers he has and uses. If he does not have one, he must apply for one. We can help him do this.
- If an individual refuses to provide his social security number, he is ineligible for assistance for himself.
- If an individual in your family or household does not wish to receive benefits, he DOES NOT have to give his social security number. If he chooses to provide his social security number, it is strictly voluntary.

### HOW WILL MY SOCIAL SECURITY NUMBER BE USED?

Social security numbers are used in matching information with the following agencies:

- Social Security Administration (SSA),
- Internal Revenue Services (IRS),
- Employment Security Commission (ESC),
- Department of Transportation (DOT),
- Out-of-state welfare and ESC agencies, and
- Any other agencies, when applicable.

We will only use social security numbers to verify income and resources.

I have read and understand the statements on this form. By signing this, I agree to allow system matches on the social security numbers I provide.

Applicant's/Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Verification Worker's/Caseworker's Signature: \_\_\_\_\_