



James O. Hacker Wellness Center  
 109 North Church Street  
 Louisburg, NC 27549

919-496-0495 Phone  
 919-496-0479 Fax  
 www.fcvmc.org

Today's Date ____/____/____
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**Applicant's Information**

First Name	Middle Name	Last Name	Social Security Number
Address			
City	State	Zip Code	County
Home Phone Number		Work Phone Number	
Date of Birth	Gender M F	Marital Status (circle) Single Married Divorced Widowed	
Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Asian			If Other
Primary Language Spoken (other than English)			
Emergency Contact Name	Relationship to Patient	Emergency Contact Phone	

**Medical History**

Allergies <i>List any drug, food or other substance allergies</i>	Medications <i>List all prescription and over the counter medications, vitamins, supplements or herbs you're currently taking</i>
Illnesses (circle any illnesses that you may have)	
<input type="checkbox"/> Acid Reflux/Ulcers <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Anxiety <input type="checkbox"/> COPD <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Seizures <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Other (list) _____	

**Physician Information**

Prescribing Physician's Name	Last seen by Physician		
Physician's Business Address	City	State	Zip Code
Physician's Phone Number			

**Insurance Benefits**

*(Check any that apply to your current benefit status)*

<input type="checkbox"/>	No Insurance/No Prescription Drug Coverage	<input type="checkbox"/>	Medicare Part D Coverage
<input type="checkbox"/>	Veterans Administration (VA)	<input type="checkbox"/>	Medicare Part D Coverage (Gap-Donut Hole)
<input type="checkbox"/>	Private Insurance Coverage	<input type="checkbox"/>	Medicaid

Applicant's Name \_\_\_\_\_

**Household Income**

How many people live in your household, including you? _____ Adults _____ Children (under age of 18)	
What is the TOTAL gross income of the ENTIRE household? _____ Month _____ Year	
Are you employed? <i>Yes No</i>	If yes, where? _____ Position _____
Have you been laid off from employment in the past year? <i>Yes No</i>	
What is the source of your household income? ( <i>Wages, Unemployment, Social Security, SSI, Disability, etc</i> )?	
Check required document(s) that you're submitting with this application as proof of income for EACH ADULT member of the household	
<input type="checkbox"/> 1040 Tax Return(s) for the current year	<input type="checkbox"/> 1099 Benefits Statement(s) for the current year
<input type="checkbox"/> 4506T Form(s) only if you did not file a federal tax return	<input type="checkbox"/> Pay Stubs from employer

**Today's Visit**

How can we assist you?	
How did you hear about FCVIM?	
Would you like to become a volunteer of FCVIM? ( <i>Check one</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Applicant's Agreement /Disclosure / Release**

I attest that information I have given in this enrollment is accurate and true, I also understand that even if my application is approved, services are not guaranteed. By signing this application, I release Franklin County Volunteers in Medicine (FCVIM), its affiliated drug companies and any public or private agencies or financial supporters and their agents from any and all claims of liability in contract or tort arising out of the actions of FCVIM, its agents, employees, or POE in performing services or related to services I receive from FCVIM. I gave my consent to DSS and DHHS to advise FCVIM of the status of a pending Medicaid application. I will notify FCVIM if I become eligible for Medicare, Medicaid, private insurance, VA benefits, or if my income changes within 30 days. I also give consent to FCVIM to disseminate my health information to its affiliates (i.e. audits by pharmaceutical companies) as it pertains to all federal, state, and local laws and regulations and purposes directly related to the administration of FCVIM programs.

Will someone other than you (applicant) be picking up your medication? ( <i>Check one</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Name _____	Relationship _____

Applicant's Signature _____	Date _____
FCVIM Employee's Signature _____	Date _____

**Office Use Only**

Appointment Scheduled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, why? _____
Referred to another agency _____		
Interviewer _____		

**Note: If appointment is scheduled, ask patient to bring in all proof of income and medicine bottles**