WV Health Right Patient Eligibility Form: (Mobile Dental)

NAME _____
Last First Middle Initial Preferred Name

ADDRESS _____
Street Address or PO Box

_____
City County State Zip Code

PHONE _____
Include Area Codes Home Work Cell

EMAIL ADDRESS _____

EMERGENCY CONTACT PHONE # _____

LANGUAGE : ENGLISH ☐ **SPANISH** ☐ **FRENCH** ☐ **OTHER** _____

Preferred method of contact: Phone ☐ **Email** ☐ **Mail** ☐ **Ok to leave message** ☐

VETERAN YES ☐ **NO** ☐ **ARE YOU PREGNANT YES** ☐ **NO** ☐

BIRTH DATE:

SOC. SEC. #:

Are you employed? ☐ **YES** ☐ **NO**
If YES, Where?

Marital Status
Married ☐
Single ☐
Widowed ☐
Divorced ☐

Race
Caucasian ☐
African American ☐
Asian ☐ Am. Indian/Alaskan ☐
Hawaiian/Pacific Islander ☐

Hispanic?
Yes ☐
No ☐

Sex
Female ☐
Male ☐
Other ☐

Homeless Status
Shelter ☐
Street ☐
Living with a friend or relative ☐

Have you been to an ER in past year? YES ☐ **NO** ☐
If YES, # of times to the ER: _____
If YES, Name of Hospital ER:

DRUG ALLERGIES? YES ☐ **NO** ☐
If YES , LIST:

Do you have a regular doctor? If yes, who? YES ☐ **NO** ☐

Physician's Name: _____

Last Grade of School Completed: ☐

Medical Insurance Status

☐ Have you APPLIED for Medicaid
☐ Veterans (V.A.)
☐ Medicaid (white card from the State of WV)
☐ Private Ins: _____
☐ Medicare (red/white/blue card)
☐ No Insurance

IMPORTANT: The section below deals with TOTAL Household information, proof of income must be provided annually and this form updated annually.

# of People in the household: ☐

WITHOUT this clinic, what would your medications cost you monthly **(please estimate)** **$** _____

List the full name & age of ALL house members and their income.	Age	Wages/ Pay period	Social Sec. Disability	Retirement	Workers Comp/ Unemployment	Veterans/& Other	TOTAL MONTHLY
Your Information ⇨		$	$	$	$	$	$
		$	$	$	$	$	$
		$	$	$	$	$	$
		$	$	$	$	$	$
Total Household income		$	$	$	$	$	$

PATIENT AGREEMENT / DISCLOSURE : I agree to allow WV Health Right to complete any patient assistance program enrollment process on my behalf, which may include disclosure of personal & medical information, soft credit check and other information necessary to determine eligibility for available drug manufacturer programs to secure my prescribed medication. Your information is confidential and secure, and only available to licensed prescribers, WV Health Right pharmacy and Administrative staff. By signing this form I attest that this information is true and accurate. I also agree that if I enroll with any medical insurer (including but not limited to Medicaid & Medicare programs) or if my financial situation changes that I will immediately notify WV Health Right. I also agree to allow pharmaceutical company auditors to review my information as needed for participation in patient assistance programs.

_____
Signature date

WVHR Staff to complete this section

Form Completed _____ Date Initials _____
HIPAA Form _____ Date Initials _____
POI Told _____ Date Initials _____
POI _____ Date Initials _____
Photo ID _____ Date Initials _____

Form Updated 12/2021

Eligibility:

Patients must be **uninsured** or have **Medicaid/Medicare** coverage and a household income at or below 250% of the Federal Poverty Level.

2025 Federal Poverty Guidelines – 250%

Household size:	Amount:
1	$39,125.00
2	$52,875.00
3	$66,625.00
4	$80,375.00
5	$94.125.00

Medical History

Last Name	First Name	SS#
City, State, Zip	Circle: ☐ Male ☐ Female	
Home Phone	Cell Phone	Date of Birth

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

Check all that apply

- ☐ Artificial Joints
- ☐ Heart Issues- Circle all that apply
  - Murmur
  - Valve Disorder
  - High Blood Pressure
  - Low Blood Pressure
  - Pacemaker
  - Rheumatic Fever
- ☐ Blood Transfusion
- ☐ Anemia
- ☐ Clotting Disorder
- ☐ Abnormal Bleeding
- ☐ Thyroid
- ☐ Kidney Disease
- ☐ Tuberculosis
- ☐ Autoimmune Disorder
- ☐ HIV
- ☐ Neurologic Disorder
- ☐ Seizure, Epilepsy, Fainting
- ☐ Arthritis
- ☐ Cancer or Tumor
- ☐ Migraines/Headaches
- ☐ Asthma
- ☐ Herpes or Cold Sores

Are you allergic to any of the following?

- ☐ Latex
- ☐ Anesthetic (Lidocaine or Novacaine)
- ☐ Antibiotics
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Ibuprophen
- ☐ Other_____

Are you using or taking any of the following?

- ☐ Tobacco
- ☐ Aspirin
- ☐ Antibiotics
- ☐ Blood Thinners
- ☐ Osteoporosis Meds
- ☐ Insulin
- ☐ Nitroglycerin
- ☐ Non Prescription Drugs
- ☐ Other_____

Are you:

- ☐ Pregnant
- ☐ Taking Hormones

Reason for dental visit:_____

_____

_____

_____

Signature:_____ **Date:**_____

WEST VIRGINIA Health Right INC.
1520 Washington Street East, Charleston, WV 25311
Phone: 304.343.7000
Fax: 304.343.7009

CONTRACT FOR DENTAL SERVICES

All patients must agree to the following conditions in order to receive dental services at West Virginia Health Right.

NARCOTICS are not provided or prescribed at West Virginia Health Right. Non-narcotic medications will be offered for pain relief and have been shown to be effective in pain management.

SLEEP ANESTHESIA is not offered at this clinic. The dentists are gentle and will assist in making you as comfortable as possible throughout the procedure(s).

ORAL HYGIENE must be practiced. We will show you how to take care of your teeth and gums after the procedures we provide. If you do not follow our instructions, we will not schedule you for additional dental work.

NO SHOW or late cancellations: We understand that there are some circumstances that might cause you to miss your appointment. Therefore, if you must cancel an appointment, you must do so at least 48 hours in advance so that another patient may fill your space. Two missed appointments may result in dismissal from the dental program. Call (304) 414-5915 for cancellations.

I agree with the above, and will do my best to comply so that the complications I may experience as a result of any dental procedure I will have, will be minimized.

Patient Signature:_____ **Date:**_____

Witness Signature:_____ **Date:** _____

WEST VIRGINIA
Health Right INC.

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164)

1. **Authorization:**
   I authorize WV Health Right, Inc. to use and disclose the protected health information to_____ (names of people).
2. **Effective Period:**
   The authorization for release of information covers the period of healthcare from:
   (a) ☐ _____to_____***OR**** (b) ☐ all past, present & future.
3. **Extent of Authorization:**
   (a) ☐ I authorize the release of my complete health record **including** records related To mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

   OR

   (b) I authorize the release of my complete health record with the **exception** of the following information:
   - ☐ Mental health records
   - ☐ Communicable diseases (including HIV & AIDS)
   - ☐ Alcohol/drug abuse treatment
   - ☐ Other(please specify)_____
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____(Date) at which time this authorization expires **OR** ☐ PERMANENTLY (no expiration date).
6. I understand that I have a right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, enrollment, or eligibility for treatment will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____/_____ _____/_____

Signature of Patient or Legal Representative /Date **Print Name of patient/Date of Birth**

WEST VIRGINIA Health Right INC

Mobile Dental Intake Instructions

Thank you for your interest in WV Health Right's Mobile Dental Program. We are very excited to be able to provide much needed dental care to our uninsured, Medicaid, and qualified Medicare patients.

Enclosed you will find the enrollment packet. Please note that each sheet is filled with important information and **MUST BE FILLED OUT COMPLETELY**. This information is very important and well be used to determine if you will be eligible to become a patient on our mobile dental unit.

Included in your packet you will find:

1. Eligibility Form (fill out completely, sign and return)
2. Medical History (fill out completely, sign and return)
3. Contract for Dental Services (fill out completely, sign and return)
4. Income Guidelines
5. HIPAA Privacy Authorization Form (complete and return)

Please make sure every form is filled out completely and signed!

*****Appointments are on a first come first served basis. If your paperwork is incomplete you will NOT be scheduled until it is complete!*****

WHEN RETURNING YOUR ELIGIBILITY PACKET PLEASE INCLUDE:

1. Copy of your Medicaid/Medicare Card
2. Proof of income: choose one of the following

- ○ **Tax Return for current year**
- ○ **1099 benefits statement for current year or Current SSI Statement**
- ○ **Current @-2 from your employer or Current check stubs**
- ○ **Current Shelter letter, Food Stamp letter, or Unemployment letter**

Mail all forms, income verification, and medical card copies to:

WV Health Right Mobile Dental Eligibility
1520 Washington Street East
Charleston, WV 25311