ST. CLAIR
Community Health Clinic
MINDS THAT CURE • HEARTS THAT CARE

205 Edwin Holiday Place Suite 125 Pell City, AL 35125 205.338.4806

Documents Needed for Clinic Intake

1. Driver's License or form of ID and Social Security Number
2. Proof of Residency (utility bill/mail with St. Clair County address)
3. Proof of Income (2024 tax filing, W2, month of pay stubs, etc..)
    a. If NO INCOME, a ZERO income Statement can be signed but must have a letter from person or persons who help you meet your needs.
4. Supplemental Information (i.e. Social Security Income or Food Stamp Letter)
5. Medicaid Denial Letter (this is free and should be obtained from the County Health Department.) (You do not have to apply for Medicaid but need to provide proof that you are not insured by Medicaid.)
6. $20 payment (cash, credit, or debit card; this covers the payment for the Intake Appointment and the Nurse Intake Appointment).

Welcome to St. Clair Community Health Clinic!

We are excited that you are here.

What can you expect from us?

We will:

1. Provide you with a primary care medical home if you:
    a. are a resident of St. Clair County, AL
    b. are between the ages of 19 and 64
    c. DO NOT have Medicaid, Medicare, or any form of insurance or health care coverage
2. Offer wholistic health services that address the body, mind, and spirit
3. Treat you with respect and dignity
4. Honor your time with short wait times to see providers and participate in wholistic services.

What will be expected of you?

1. As a wholistic clinic, we have a number of specialty services including but not limited to behavioral health, social services, dietary counseling, exercise therapy, etc. Together you and our team will identify wholistic services that will be helpful for you. As a registered clinic patient, we expect that you will participate in these wholistic health services.
2. We operate by appointment times. We expect you to make and keep appointments. If you are unable to keep an appointment time, we expect you to call and cancel/reschedule your appointment so that other patients can be seen. If you miss 3 appointments without cancellation, you are subject to dismissal from the clinic.
3. There is a $20 fee for provider service that is due at the time of visit. Wholistic services will be provided at no or minimal fee for registered clinic patients.
4. SCCHC is staffed by volunteers that are here donating their time to assist you as a health partner. Our staff will serve you with respect and high-quality care. In turn we expect our staff to be treated with respect. If a disagreement or misuse of this partnership should arise, the clinic reserves the right to discontinue services.
5. Recognize that we do not prescribe narcotic or other controlled substances and do not keep them on the premises.

By signing below, you agree to abide by the above expectations.

______________________	______________________	____________
Signature of patient	Signature of staff	Date

Medical Records Release Consent

I, the undersigned, am a patient of St. Clair Community Health Clinic.

I authorize St. Clair Community Health Clinic to obtain from you and authorize you to release my complete medical records or any portion thereof.

The purpose of this request is for continuity of my medical care.

You are authorized to provide this information via fax or U. S. Mail to:

Medical Records

St Clair Community Health Clinic

205 Edwin Holladay Place

Pell City, AL 35125

Phone: 205.338.4806

Fax: 205.338.4476

If my medical records maintained by you include information relating to

a. Sexually transmitted disease
b. Disease required by law to be reported to the County Health Department
c. HIV / AIDS
d. Treatment for alcohol and drug abuse
e. Mental/ behavioral health services,

I specifically authorize the release of all this information to St. Clair Community Health Clinic.

I understand that, if in the course of my medical care, St. Clair Community Health Clinic determines that referral is necessary, the information provided under this consent, or a portion of my chart, may be disclosed to aid in the continuity of my medical care. I also understand that the information provided under this consent may be disclosed to any new medical provider upon my request.

____________________________________ __________________

Signature of Patient Date

____

Signature of Witness

Consent to Release Information

Patient Name: ______________________________

Date of Birth: ____________

Any St. Clair Community Health Clinic staff member has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following persons to facilitate and coordinate care, treatment, and payment.

Name: ______________________________

Relationship: ______________________________

Phone: ______________________________

Name: ______________________________

Relationship: ______________________________

Phone: ______________________________

Name: ______________________________

Relationship: ______________________________

Phone: ______________________________

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form if I have not listed anyone. I can revoke this permission at any time by notifying St. Clair Community Health Clinic in writing or by completing a new form and returning it to St. Clair Community Health Clinic.

______________________________ ____________

Signature of Patient or Responsible Party Date

St Clair Community Health Clinic

205 Edwin Holladay Place

Pell City, AL 35125

Phone: 205.338.4806

RELEASE

I authorize the release and disclosure of any or all of my medical and treatment records or reports to any other health care provider who may be of assistance in the opinion of St. Clair Community Health Clinic staff and/or assisting in any medical benefits to which the patient may be qualified to receive.

I allow fax transmittals of my medical records if necessary.

I authorize treatment by St. Clair Community Clinic providers and personnel.

I have read and fully understand.

Initial the following to acknowledge receiving and permissions:

_____ Notice of Privacy Practices

_____ Patient Agreement

_____ Permissions to Obtain My Medication History

______________________________ __________

Patient Signature Date

St Clair Community Health Clinic

205 Edwin Holladay Place

Pell City, AL 35125

Phone: 205.338.4806

ST. CLAIR COMMUNITY HEALTH CLINIC

ZERO INCOME AFFIDIVAT

(To be completed by patient requesting services)

Household Name: ____

Property Address: ____

City: ______________________________ State: __________ Zip: __________

1. I, ____________________ hereby certify that I do not individually receive income from any of the following sources:
    a. Wages from employment (including commissions, tips, bonuses, fees, pay in lieu of vacation or sick time, profit sharing, etc.);
    b. Income from operation of a business;
    c. Rental or royalty income from real or personal property, or gain from the sale of a property;
    d. Interest or dividends from assets;
    e. Social Security payments, annuities, insurance policy benefits, distributions from retirement funds, pensions, or death benefits;
    f. Unemployment or disability payments;
    g. Severance pay;
    h. Public assistance payments;
    i. Periodic allowances such as alimony, child support or regular periodic gifts received from persons not living in my household;
    j. Veteran's benefits;
    k. Gambling winnings
    l. Any other source not named above.
2. I currently have no income of any kind and there is no imminent change expected in my financial status or employment status in the next 12 months.

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. I further understand that providing false representations herein constitutes and act of fraud. I acknowledge the information is being used for the specific purpose of determining eligibility to receive assistance through St. Clair Community Health Clinic and associated partnerships that may support and augment care. If requested, I will fully cooperate with any request to provide documents to verify the information provided within.

____________________ ____________________ ____________

Printed name of applicant Driver's License Number Date

Signature of applicant ______________________________

Sworn to and subscribed before me on this the ____ day of ____________, 2025.

______________________________ ______________________________

Notary Public My Commission Expires:

LETTER OF SUPPORT

Date: ____________

Applicant's Name ___________________ Applicant's DOB _______

Supporter's Name ____

Supporter's Relationship to Applicant: ___________________________

Supporter's Phone Number: ____________________________________

This letter is to certify that (patient's name) _________________ receives too little / no income and that I am assisting with his/her living expenses.

Please check one of the following:

____ Option 1: Applicant lives with me and I provide all the financial support, housing, utilities, food, and other expenses.

____ Option 2: I provide the applicant with $______ per month in financial assistance.

____ ____________

Signature of Supporter Date

St Clair Community Health Clinic

205 Edwin Holladay Place

Pell City, AL 35125

Phone: 205.338.4806

AFFIDAVIT OF NO INSURANCE

I, ______________________________, do hereby affirm that I have no private or group health insurance. Neither do I have Medicare or Medicaid benefits. I do not have health insurance coverage under any family member or any other entity.

To the best of my knowledge these statements are true and correct.

____

Printed Name

____

Signature

Sworn to and subscribed before me on this the ____ day of _____________, 2025.

_____________________________ _____________________________

Notary Public My Commission Expires:

St Clair Community Health Clinic

205 Edwin Holladay Place

Pell City, AL 35125

Phone: 205.338.4806

DEMOGRAPHICS

Name:____

Address:_________________________City,__________ Zip_______

Phone:__________________________Date of Birth_______________

Text: Yes_________ No __________

Email: ____

Emergency Contact:

____

Contact #:____

Relationship:____

Alternate #____

Name:____

Relationship:____

Alternate #____

Name:____

Relationship:____

Alternate #____

Name:____

Relationship:____

UAB St Vincent's

Ascension St Vincent's Birmingham

Summary of Financial Assistance Policy

UAB St Vincent's, including the health ministries listed above, have a commitment to and respect for each person's dignity with a special concern for those who struggle with barriers to access healthcare services UAB St Vincent's has an equal commitment to manage its healthcare resources as a service to the entire community. In furtherance of these principles, UAB St Vincent's provides financial assistance for certain individuals who receive emergency or other medically necessary care from Ascension St Vincent's. This summary provides a brief overview of UAB St Vincent's Birmingham's Financial Assistance Policy.

Who Is Eligible?
You may be able to get financial assistance if you live in Jefferson, Blount, Chilton, Cullman, Shelby, St Clair, Talladega or Walker County. Financial assistance is generally determined by your total household income as compared to the Federal Poverty Level. If your income is less than or equal to 250% of the Federal Poverty Level, you may receive a 100% charity care write-off on the portion of the charges for which you are responsible. If your income is above 250% of the Federal Poverty Level but does not exceed 400% of the Federal Poverty Level, you may receive discounted rates on a sliding scale. If you have medical debt for emergency and medically necessary care that exceeds your income, you may be eligible for a discount. If you have assets in excess of 250% of your Federal Poverty Level income amount you may not qualify for financial assistance. Patients who are eligible for financial assistance will not be charged more for eligible care than the amounts generally billed to patients with insurance coverage.

What Services Are Covered?
The Financial Assistance Policy applies to emergency and other medically necessary care. These terms are defined in the Financial Assistance Policy. All other care is not covered by the Financial Assistance Policy.

How Can I Apply?
To apply for financial assistance, you typically will complete a written application and provide supporting documentation, as described in the Financial Assistance Policy and the Financial Assistance Policy application.

How Can I Get Help with an Application?
For help with a Financial Assistance Policy application, you may contact

Financial Counselor Office
Phone Number: 844-483-7710

How Can I Get More Information?
Copies of the Financial Assistance Policy and Financial Assistance Policy application form are available at uabstvincents.org and at Financial Counselors Office at Ascension St Vincent's. Free copies of the Financial Assistance Policy and Financial Assistance Policy application also can be obtained by mail by emailing https://uabstvincents.org/billing/contact-billing-financial-services/. Additional information about the Financial Assistance Policy also is available at Financial Counselors at Ascension UAB St Vincent's or by telephone at 844-483-7710.

What If I Am Not Eligible?
If you do not qualify for financial assistance under the Financial Assistance Policy, you may qualify for other types of assistance. For more information, please contact Financial Counselors Office at UAB St Vincent's or by telephone at 844-483-7710.

Translations of the Financial Assistance Policy, the Financial Assistance Policy application and instructions, and this plain language summary are available in the following languages on our website and upon request:

English
Spanish
Simplified Chinese
Traditional Chinese

Financial assistance application form

UAB ST. VINCENT'S

Patient information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)

Date________________________ Account number ________________

Name (first and last)____

Birth date________________________ Marital status____________ Phone number ________________

Mailing address________________________________ City________________ State______ ZIP______

Social security number (optional) ________________________________

Employer________________________________ Employment status________________

Number of hours worked per week________________ Employer phone number________________

Responsible party's information/legal guardian's information

(If patient above is same as responsible party, leave this section blank.)

Name (first and last)____

Birth date________________________ Marital status____________ Phone number ________________

Mailing address________________________________ City________________ State______ ZIP______

Social security number (optional) ________________________________

Employer________________________________ Employment status________________

Number of hours worked per week________________ Employer phone number________________

Responsible party spouse information

(If patient is same as responsible party, fill in spouse information for patient.)

Name (first and last)____

Birth date________________________ Marital status____________ Phone number ________________

Mailing address________________________________ City________________ State______ ZIP______

Social security number (optional) ________________________________

Employer________________________________ Employment status________________

Number of hours worked per week________________ Employer phone number________________

Dependents of responsible party

(If patient is same as responsible party, fill in spouse information for patient.)

Name________________________ Birth date____________ Relationship to responsible party ____________

Name________________________ Birth date____________ Relationship to responsible party ____________

Name________________________ Birth date____________ Relationship to responsible party ____________

Name________________________ Birth date____________ Relationship to responsible party ____________

Number of adults and children living in household ________________________

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income ____________________

Applicant spouse income ____________________

Social security benefits ____________________

Pension/retirement income ____________________

Disability income____________________

Unemployment compensation ____________________

Worker's compensation ____________________

Interest/dividend income ____________________

Child support received ____________________

Alimony received ____________________

Rental property income ____________________

Food stamps ____________________

Trust fund distribution received ____________________

Other income ____________________

Other income ____________________

Total gross monthly income $ ____________________

Monthly living expenses

Mortgage/rent____________________

Utilities____________________

Phone (landline) ____________________

Cell phone ____________________

Groceries/food____________________

Cable/internet/satellite tv ____________________

Car payment ____________________

Child care ____________________

Child support/alimony ____________________

Credit cards ____________________

Doctor/hospital bills ____________________

Car/auto insurance ____________________

Home/property insurance ____________________

Medical/health insurance ____________________

Life insurance ____________________

Other monthly expense ____________________

Total monthly expenses $ ____________________

Assets

Cash/savings/checking accounts ____________________

Stocks/bonds/investments/CD(s)____________________

Other real estate/secondary residence ____________________

Boat/RV/motorcycle/recreational vehicle ____________________

Collector automobiles/non-essential automobiles ____________________

Other assets ____________________

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Signature of Applicant____________________

Date ____________________

Comments ____________________