



🏠 31 1st Avenue SE, Hickory, North Carolina  
28602

☎ 828.578.7466 fax. 828.345.0517

✉ [jmartinez-garcia@ccmhickory.org](mailto:jmartinez-garcia@ccmhickory.org)

**2025 GHCCM Health Application  
Demographic Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
Address Line: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

# Of Adults in Household: \_\_\_\_\_ | # of Children Under 20: \_\_\_\_\_

**Marital Status:**

Married  Single

**Race:**

White  Black  Hispanic/Latino  Asian  Pakistani  Other: \_\_\_\_\_

**Gender:**

Male  Female  Other: \_\_\_\_\_

**Citizenship:**

U.S. Citizen  U.S. Resident

**Veteran Status:**  Yes  No

**Highest Grade Completed** \_\_\_\_\_

**Insurance:**

Do you have health insurance?  Yes  No

Do You Have:

Medicaid  VA Benefits  Private Insurance

Insurance Provider: \_\_\_\_\_

Type of Coverage: \_\_\_\_\_

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**Employment:**

Are you currently working?  Yes  No



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**Income: Do you receive any of the following?**

- Employment Income     
  Child Support/Alimony     
  Disability     
  Social Security     
  Unemployment  
 Retirement     
  Self-Employment Income     
  Food Stamps/SNAP

Income Source	Patient	Spouse/Partner	Child (if employed)	Child (if employed)	Child (if employed)	Child (if employed)
Wages	\$	\$				
Child Support/Alimony	\$	\$				
Disability	\$	\$				
Social Security	\$	\$				
Retirement	\$	\$				
Unemployment	\$	\$				
Food Stamps	\$	\$				
VA Benefits	\$	\$				
Self-Employment	\$	\$				
Contributions	\$	\$				
Total	\$	\$				
Combined Total	\$	\$				

**Health Information:**

Are you diabetic?  Yes  No

**Authorization & Acknowledgment:**

- I will notify Greater Hickory Cooperative Christian Ministry of any changes in my insurance status or household income within **one (1) week** of the change.
- I attest that all information recorded in this document is true and correct to the best of my knowledge.
- I authorize GHCCM to review my records for verification purposes, including review by pharmaceutical representatives supplying my medications.
- I give permission for GHCCM to obtain medications on my behalf through the Prescription Assistance Program. My signature grants GHCCM the authority to sign the required forms on my behalf.
- **I authorize GHCCM to input my personal and health information into the Charity Tracker and Unite Us network systems** for the purpose of coordination of care and assistance across partner agencies.

**Applicant/Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Intake Representative/Community Health Worker Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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### Zero Income Certification

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. **How long have you been without income?**

\_\_\_\_\_

2. **Why do you currently have zero income?**

\_\_\_\_\_

3. **Are you applying for disability benefits?**

Yes       No

4. **How are your basic needs being met? Who is paying your bills?**

\_\_\_\_\_

\_\_\_\_\_

5. **What is your plan to improve your financial situation?**

\_\_\_\_\_

\_\_\_\_\_

6. **How else can GHCCM assist you?**

\_\_\_\_\_

\_\_\_\_\_

**Interviewer Comments:**

\_\_\_\_\_

\_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_ / \_\_\_ / \_\_\_\_\_

**Interviewer Signature:** \_\_\_\_\_ **Date:** \_\_\_ / \_\_\_ / \_\_\_\_\_



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## SELF-DECLARATION OF HOMELESSNESS

I, \_\_\_\_\_, declare that I am currently without a permanent place of residence.

**I receive mail at:**

(Address Line 1) \_\_\_\_\_

(Address Line 2) \_\_\_\_\_

(City) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

*This address is used for mailing purposes only.*

**I am currently receiving services from the following agencies in Catawba County:**

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I understand that under penalty of fraud, the above information is true and accurate.  
If it is found that I have provided false or misleading information, GHCCM reserves the right to suspend or deny services to me.

**Client Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Interviewer Signature:** \_\_\_\_\_



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SELF-EMPLOYMENT INCOME DECLARATION

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

Who is this form being completed for?

Self Spouse/Partner Child Other: \_\_\_\_\_

Do you work for yourself (self-employed)? Yes No
Do you also work for other people? Yes No
Do you provide work tickets or receipts? Yes No
Do you file income taxes? Yes No

Describe the type of work you do:

Three horizontal lines for describing work type.

List the dates and earnings for the last 3 months below:

Table with 3 columns: Date, Job Description, Amount. 6 rows.

Total: \$ \_\_\_\_\_

I hereby certify that the above information is true and accurate to the best of my knowledge.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Notice Regarding the Use of Social Security Numbers (This is not an application)

If members of your household wish to receive benefits such as **Food Assistance, Medical Assistance, Special Assistance, or Work First Family Assistance**, they must provide Social Security Numbers (SSNs). Only those who provide or apply for an SSN will receive benefits if determined eligible.

**Applications for Food Assistance or Work First Family Assistance will not be delayed or denied solely because a household member does not provide an SSN.** However, these individuals may still be asked to answer other questions on the application related to the household’s financial circumstances.

This notice only applies to the use of Social Security Numbers.

### Important Information:

- Anyone in your household who wants to receive assistance **must provide all Social Security Numbers they have and use.**
- If a person **refuses to provide their SSN**, they will **not be eligible** for assistance.
- If a person in the household **does not wish to receive benefits**, they are **not required** to provide an SSN. Providing a Social Security Number in this case is **completely voluntary.**

### How Will My Social Security Number Be Used?

Your SSN may be shared with and used by the following agencies solely for verifying income and eligibility:

- **Social Security Administration (SSA)**
- **Internal Revenue Service (IRS)**
- **Employment Security Commission (ESC)**
- **Department of Transportation (DOT)**
- **Out-of-state public assistance and child support enforcement agencies**
- **Any other relevant government agency as permitted by law**

Your Social Security Number will only be used to verify **income and assets** to determine eligibility for benefits.

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### Permission to Verify Medicaid Eligibility

By signing this form, you also give permission for our **DSS Liaison** to verify your **Medicaid eligibility status** directly with the Department of Social Services (DSS), as part of the application process for health-related services.

I have read and understand the statements in this notice. By signing below, I give permission for the Social Security Numbers I provide to be used for verification purposes through authorized systems, and for the DSS Liaison to check my Medicaid eligibility.

**Applicant/Representative Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Verification Worker/Social Worker Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_



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## AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION TO AND FROM GHCCM/ PRIVACY POLICY OF HIPPA

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Chart #: \_\_\_\_\_

### Section I – Authorization to Share Medical Information

I, \_\_\_\_\_, authorize **Greater Hickory Cooperative Christian Ministry (GHCCM) Clinic (Dr. John Earle Medical Ministries) and Pharmacy** to share my protected health information as described in Section II below, with the following individuals or organizations for the purpose of **medical care coordination, referrals, testing, pharmacy services, and/or eligibility evaluation.**

### Section II – Type of Information to Be Disclosed

I authorize GHCCM to:

**Release my complete medical record**, including but not limited to: diagnoses, lab results, treatment plans, medication history, and billing records related to all health conditions.

**OR**

**Release my complete medical record EXCEPT** the following information:

Mental health

Communicable diseases including, but not limited to, HIV/AIDS

Records related to alcohol and/or drug treatment

Genetic information

Other (please specify): \_\_\_\_\_

### Section III – Patient Rights and HIPAA Privacy Notice

GHCCM abides by the **Health Insurance Portability and Accountability Act (HIPAA)** and maintains the confidentiality and security of all patient records. Your protected health information (PHI) will only be shared for authorized purposes and in accordance with federal and state privacy laws.

- I understand that I may **revoke this authorization at any time** by submitting a written request to GHCCM.
- I understand that revoking this authorization may impact the ability of GHCCM to schedule referrals, tests, or coordinate services on my behalf.
- I understand that any information already released prior to the revocation cannot be retracted.
- I understand that refusing to sign or canceling this authorization **will not prevent me from receiving services** at GHCCM unless the information is required to determine eligibility for certain services.
- I acknowledge that a **copy of GHCCM’s Notice of Privacy Practices (HIPAA policy)** is available upon request.

Signature of Patient or Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**If signed by someone other than the patient, indicate relationship:**

Parent  Legal Guardian  Power of Attorney  Other: \_\_\_\_\_