



Mercy
HEALTH CLINIC



MONTGOMERY CARES ENROLLMENT

NEW & RETURNING PATIENTS WELCOME!



We are happy to help you and your family
get medical care at low cost.



HOW TO APPLY

Stop by the clinic Monday–Thursday
to pick up an application.



APPLICATION PICK-UP HOURS

Monday & Wednesday:

9:00 AM – 4:30 PM

Tuesday & Thursday:

9:00 AM – 7:30 PM



MONTGOMERY CARES ENROLLMENT HOURS

Please come during these times:

Tuesday: **4:00 PM – 7:00 PM**

Wednesday: **12:00 PM – 3:00 PM**



FRIDAY – CLOSED



2026 INCOME GUIDELINES (250% Montgomery Cares Program)

FAMILY SIZE	MAXIMUM YEARLY INCOME
1	\$39,900
2	\$54,100
3	\$68,300
4	\$82,500
5	\$96,700
6	\$110,900
7	\$125,100
8	\$139,300



Add **\$14,200** for each
extra person after 8 people.



WHO CAN APPLY?

You may qualify if:

- ✓ You live in Montgomery County
- ✓ You are 18 years or older
- ✓ You have low income
- ✓ You do **NOT** qualify for health insurance



DOCUMENTS YOU NEED TO BRING



PHOTO ID

Bring **ONE**: (not expired)

Any photo ID (Passport, Driver's License, Maryland ID etc.)



PROOF OF INCOME

Bring **ANY** that apply to you:

- Signed Taxes / W2 / 1099
- Last 4 paystubs
- Employer Letter
- Unemployment Letter
- Retirement Income Letter
- Support letter from family or friend



PROOF YOU LIVE IN MONTGOMERY COUNTY

Bring **ONE**:

- Maryland ID or License
- Lease
- Recent paystubs
- Signed Taxes/W2/1099
- Letter + utility bill from landlord



**WE CANNOT
ACCEPT:**

- ✗ Cell phone bills
- ✗ Bank statements
- ✗ Car insurance bills
- ✗ Hospital bills



Mercy Health Clinic
7 Metropolitan Court, Ste 1
Gaithersburg, MD 20878



240-773-0300



MercyHealthClinic.org



STAFF PAPERWORK

New / Renewing

Full Name (as per ID) / *Nombre Completo*

DOB/Fecha de Nacimiento

1. Are you a Greencard holder for **less** than **5 years**?/ *Tiene residencia permanente menos de 5 años?* ☐ Yes / *Sí* ☐ No How many years? _____

2. Do you have a Social Security Number?/ *¿Tiene un número de Seguro Social?* ☐ Yes / *Sí* ☐ No

If yes, through WORK PERMIT? *Si es sí, por PERMISO DE TRABAJO?* _____

3. Do you have health insurance? *¿Tiene o ha tenido seguro médico en el pasado?* ☐ Yes / *Sí* ☐ No

If yes, name of the insurer:/ *Si contestó sí, nombre del seguro:* _____

4. Have you been a patient at another clinic in the past 2 years?/ *¿Ha sido paciente de alguna otra clínica en los últimos 2 años?* ☐ Yes / *Sí* ☐ No If yes, name of the clinic:/ *Si contestó sí, nombre de la clínica:* _____

5. Are you financially dependent on someone else? / *¿Dependes económicamente de otra persona?* ☐ Yes / *Sí* ☐ No

***** (FOR MERCY STAFF USE ONLY) *****

☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired

Total combined annual income of all employed individuals \$ _____ Total # of people _____

Notes:

Please check the documentation provided for proof of address, income, and age for each Patient.

Proof of Address

☐ Driver's License/ State ID ☐ Letter- Landlord +Lease/Utility Bill within **60 days** ☐ School Records
☐ W2/Tax Return/1099 ☐ Recent paystubs ☐ Mortgage/Lease ☐ Letter: County or State
☐ Utility Bill (gas, electric, water, cable/internet) ☐ Other: _____

Proof of Age

☐ Passport ☐ Driver's License/State ID ☐ Other: _____

Proof of Income

☐ DHHS Income Declaration Form ☐ Income Letter: Employer/Disability/Unemployment/Retirement
☐ Recent Paystubs ☐ **No Income:** Letter of Support from Family or Friend
☐ W2/Tax Return/1099 ☐ Other: _____

NOTE: The patient is missing the following documentation:

____ Proof of address: _____
____ Proof of ID: _____
____ Proof of income: _____

Staff Name: _____ Date: _____

Data Entry Name: _____ ☐ completed, scanned, & added to excel MRN# _____



MONTGOMERY COUNTY SAFETY-NET PROGRAMS APPLICATION

COUNTY OFFICIAL USE ONLY:

eICM Contact ID: _____

Case Number: _____

Head of Household Name (Last, First, Middle)		Home Telephone		Work Telephone		Cell Telephone		
Where Do You Live? (Number and Street)		Apt. #		City		State		
Mailing Address (if different from home address)						Zip Code		
What language do you speak? ☐ English ☐ Spanish ☐ Amharic ☐ French ☐ Korean ☐ Mandarin ☐ Vietnamese ☐ Other _____								
Are you or anyone in your household pregnant? ☐ Yes ☐ No If yes, who? _____				Due Date _____				
Have you ever received a county health program benefit program? ☐ Yes ☐ No				Under what name? _____				
SECTION A. HOUSEHOLD MEMBERS								
Fill in the blanks for all the people in your household. Check YES for each person you are applying for. Check NO for each person you are not applying for. Check services you are requesting.								
APPLYING FOR	NAME (Last, First, Middle)	RELATION TO YOU:	DATE OF BIRTH MM/DD/YY	GENDER	MARITAL STATUS	*RACE (Indicate below for each person)	*ETHNICITY	Please complete for each person who has a Social Security number
☒ MONTGOMERY CARES ☐ CARE FOR KIDS ☐ SENIOR DENTAL	↑	↑	↑	M = Male F = Female NB = Nonbinary GQ = Genderqueer/ Genderfluid MTF = Transwoman/ woman of transgender experience FTM = Transman/ man of transgender experience	M = Married S = Single D = Divorced P = Separated W = Widowed	A = Asian B = Black/African American C = White N = American Indian or Alaska Native P = Native Hawaiian or Pacific Islander (You may select more than one code) ME/NA = Middle Eastern or North African	H/L = Hispanic/ Latino N/L = Non-Hispanic/ Non-Latino	SOCIAL SECURITY NUMBER (SSN) ↑
☐ Yes ☐ No	↑	SELF	↑		↑		☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	
☐ Yes ☐ No							☐ H/L ☐ N/L	

*You do not have to give information about your race/ethnicity. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter codes for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.

SECTION B. ADDITIONAL INFORMATION

Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Medicare ☐ Qualified Health Plan (QHP) ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Medicare ☐ Qualified Health Plan (QHP) ☐ Private-Payer ☐ Employer-Based
Name (Last, First, Middle)	Country of Birth	Do you currently have active health insurance coverage: ☐ Yes ☐ No If yes, please identify which type of plan you have: ☐ Medicaid ☐ Medicare ☐ Qualified Health Plan (QHP) ☐ Private-Payer ☐ Employer-Based

SECTION C. EARNED INCOME

Does anyone in your household receive any income from employment? ☐ Yes ☐ No If yes, list all gross income (from full or part-time employment, self-employment, babysitting, odd jobs, day work, roomer/boarder payments)

NAME (Last, First, Middle)	EMPLOYER	RATE OF PAY (HOURLY)	NUMBER OF HOURS WORKED	GROSS AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED WE = Weekly BW = Bi-weekly MO = Monthly	JOB START DATE (MM/DD/YY)	JOB END DATE (MM/DD/YY)	STUDENT STATUS (Full or Part-time)

SECTION D. UNEARNED AND OTHER INCOME

List any other income received such as alimony, child support, pension, Social Security, income received from renting property to others, and benefits (retirement, strike benefits, unemployment, veterans, workers compensation). Include out-of-state benefits.

PERSON RECEIVING INCOME	TYPE (For benefits, include Claimant ID#)	GROSS AMOUNT RECEIVED	HOW MANY TIMES A YEAR?

SIGNATURE SECTION

I certify that the information I have provided above is true to the best of my knowledge and I give permission for Montgomery County to make any necessary contacts to check my statements. I have read and agree to the rights and responsibilities in this application packet. I know that I can be penalized if I knowingly give false information, and I declare under penalty of perjury that I do not have health insurance coverage and the facts I state in this application are true, correct, and complete to the best of my ability, belief, and knowledge.

Signature of Applicant/Recipient	Print (Name)	Date



Authorization Form for Family Members/Friends

Patient Name: _____ DOB: _____

Email: _____ Cell#: _____

I, _____, give permission to all my health care and medical services providers to disclose and release my protected health information described below to:

Name(s):	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____

Health Information to be disclosed (Check all that apply):

☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

☐ My complete health record, as above, except for the following information (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

Appointment time that works best with you: (check one)

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

This authorization shall be effective until: (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Signature

Date



NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Your PHI may be used and disclosed by Mercy Health Clinic, our office staff and others outside of our office involved in your care and treatment to provide health care services to you.

The following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. We will also disclose protected health information to other physicians who may be treating you.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider.

Health Care Operations: We may use or disclose, as needed, your protected health information to support the clinic's business activities. These activities include quality assessment activities, employee review activities, training medical students, fundraising activities, and conducting or arranging for other business activities. We will share your protected health information with third party "business associates" that perform various activities (for example, billing transcription services) for our practice. We may use or disclose your protected health information, as needed, to provide you with information about treatment alternative or other health-related benefits and services that may interest you.

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange to provide faster access, better coordination or care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.

I _____ (Patient Name) have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my medical information. Accordingly, I knowingly and voluntarily authorize any Mercy Health Clinic Member to use or disclose my medical information in the manner described above. I understand and agree that this Authorization applies only to the extent that an Authorization is required by law in order to Mercy Health Clinic Members to use or disclose my medical information in the manner described.

Full Name (as per ID)

Signature

Date



PATIENT'S RIGHTS AND RESPONSIBILITIES POLICY

1. I understand that Mercy Health Clinic (MHC) is not a government program or an insurance company, but a non-profit clinic dependent on donations and grants to cover its operating costs.
2. While I understand that I will not be denied care for the inability to pay, I acknowledge that the clinic appreciates a voluntary cash contribution of **\$20.00** for primary care and lab visits, and **\$40.00** for specialty care.
3. I understand that a **\$100.00** fee will be charged if I cancel or miss my scheduled appointment without providing proper notice on the same day ("**No Show**").
4. I understand that once my appointment is scheduled, it is my responsibility to remember the date and time and to keep the appointment.
5. I understand that if I need to cancel or reschedule an appointment, I must call or leave a message at least 24 hours in advance at 240-773-0300 or email appointments@mercyhealthclinic.org.
6. I understand that the following behaviors may result in termination from clinic services or external resources:
 - a. **Noncompliance with treatment as instructed by the physician**
 - b. **Misconduct or rudeness**
 - c. **Misuse of services**
 - d. **Failure to show up ("No Show") for any scheduled appointments**
7. I understand that MHC is not responsible for any medical bills incurred from outside doctors or specialists unless I have received a referral from Mercy Health Clinic and followed the given instructions.
8. I understand that MHC does not provide comprehensive medical care and operates only on the following days and times:
 - a. **Clinic/Pharmacy Hours:**
Monday and Wednesday: 8:30 am - 5:00 pm
Tuesday and Thursday: 8:30 am - 8:00 pm
Closed on Fridays
 - b. **Laboratory Hours:**
Monday and Wednesday: 7:00 am - 10:30 am
 - c. **Montgomery Cares Program Enrollment Hours:**
Tuesday: 4:00 pm – 7:00pm & Wednesday: 12:00 pm - 3:00 pm
9. "I understand that the Montgomery Cares program is not available to patients who qualify for health insurance. If you are a green card holder or U.S. citizen, you must apply for Maryland Health Connection and provide an approval or denial letter to continue receiving services under the MCares program.
10. I understand that MHC accepts the following insurances: Medicaid, WellPoint, Maryland Physician Care, and CareFirst BCBS.
11. I understand that it is my responsibility to renew with the Montgomery Cares program every year before the expiration date. I must provide proof of ID, proof of address, and proof of income. Failure to renew will prevent me from keeping my scheduled appointments with the physician.
12. I understand that it is my responsibility to inform MHC of any changes to my income, address, or phone number.

Full Name (as per ID)

Signature

Date



MEDICAL RECORD RELEASE FORM

Full Name /Nombre Completo: _____

DOB/Fecha de Nacimiento: _____ Tel: _____

Address/Dirección: _____

DO NOT WRITE BELOW THIS LINE / NO ESCRIBA DEBAJO DE ESTA LÍNEA (STAFF USE ONLY)

Name of Provider, Hospital, or Clinic: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Date(s) of Service: From: _____ To: _____

If release/request of records is to be sent to Mercy Health Clinic, we would appreciate a summary of diagnostic studies, laboratory reports, x-rays, and any other pertinent medical information.

The release/request of records is to be sent to:

Mercy Health Clinic
7 Metropolitan Court, Suite 1
Gaithersburg, MD 20878
Phone: 240-773-0300 Fax: 240-773-0308

I hereby authorize the release of my medical records as indicated above:

Signature

Date