THE FREE CLINIC OF MERIDIAN

4707 Poplar Springs Drive

Meridian, MS 39305

601-286-5551

freeclinicofmeridian@gmail.com

Patients are seen by appointment only after approval of application.
Approval may take 2-4 weeks.

The Free Clinic of Meridian provides chronic disease diagnosis and management (diabetes, hypertension, respiratory illnesses, etc.), preventive medicine (blood pressure checks, cholesterol testing, etc.) and health education at no cost. All services are provided by volunteer medical providers.

To be eligible for service, individuals must meet the following criteria:

1. Be without health care insurance and be ineligible for Medicaid or Medicare.
2. Be the age of 19 or older until eligible for Medicare.
3. Have a total family income no greater than 200% of the Federal Poverty Guidelines (see below)
4. Present a photo ID card (driver's license, student ID, etc.)
5. Provide a Social Security number
6. Present Proof of Income--current pay stubs, W2 forms , income tax returns, food stamp allocations, child support, etc. for all members of the household
7. Information presented will be verified prior to acceptance as a patient at the Free Clinic of Meridian.

Clinic hours

Monday, Tuesday, Wednesday, Thursday 9:00-12:00; 1:00-4:00

Please arrive 1 hour before closing if picking up or submitting an application.

Closed the weeks of Thanksgiving and Christmas

200% of 2024 Federal Poverty Guidelines
200 % de 2024 pautas federales de pobreza

Family Size Monthy Tamano de la familia Mensual	
1	$ 2,510
2	$ 3,407
3	$ 4,303
4	$ 5,200
5	$ 6,097
6	$ 6,993
7	$ 7,890
8	$ 8,787

Each additional person in the household,
add $448.33 per month.
Cada persona adicional en el hogar,
anadir $448.33 por mes

New Patient Application Checklist

Please make sure all items are included with the application. **We do not accept the application without all the information needed.** Thank you!

_____Completed Applications. All areas are filled in completely including dated signatures.

_____Color Copy of Photo ID.

_____Social Security Number (we do not require a copy)

_____Proof of Household Income: This should be at least ONE of the following:

- _____Copy of at least 2 RECENT pay stubs
- _____W-2 form, or tax form from previous year
- _____SNAP Form
- _____Child Support Printout
- _____No income Questionnaire: If filling out the No Income Questionnaire, please be sure that in addition to the questionnaire, the applicant provides a letter from the church or organization that is assisting with household expenses, or a notarized letter from the individual that is assisting with household expenses.

Thank You!

Patient Registration

First Name:_____ Middle Name:_____ Last Name:_____

Age _____ Date of Birth:_____ Sex:_____ Social Security #:_____

County of Residence: _____Address: _____

City: _____ State: _____ Zip : _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Any other phone number: _____ May we leave a message? __yes __no

Email Address: _____ U.S. Citizen: __yes __no

How many people live in your household? _____ What are their ages? ____ ____ ____ ____ ____ ____ ____

Current income for the entire household: _____ per: __week __month __year

Your Employer: _____ Employer's Phone: _____

Spouse Name: _____

Spouse's Employer: _____Spouse's Employer's Phone:_____

Are you ___Disabled ____ Unemployed Have you applied for Disability? __Yes __No

Have you applied for Unemployment? ___Yes ___No

Disability Income: _____ per __month __year Unemployment Income: _____ per __month __year

Do you have any type of insurance? ____Work ___Medicare ___Medicaid ___ Other

Have you applied for Medicaid or Medicare? __Yes __No If yes, were you turned down? ___yes ___no

If yes, why were you turned down?_____

Marital Status: ___Married ___Single ___Widowed ___Divorced

Ethnicity: __African American __ White __Hispanic __Asian __Other

Who referred you to our clinic? _____

Emergency Contact: _____ Emergency Contact Phone #_____

_____ _____

Patient Signature Date

___Eligible ___Ineligible (Explain below) Name of reviewers _____

Date_____ _____

If ineligible, why? ___Insured ___Medicaid ___Medicare ___Under 19

___Above income requirements Other_____

For Office Use Only

Free Clinic of Meridian
Patient Health History

Name:_____ Date of Birth:_____

Who is your primary doctor or health care provider? _____Date last seen:_____

Reason for seeking medical care: _____

Check **YES** if you have had any of the following:

Yes		When Diagnosed		Yes		When Diagnosed
	Asthma				Congestive Heart Failure	
	Emphysema				Heart Attack	
	High Blood Pressure				High Cholesterol	
	Diabetes				Cancer	

List any other health problems:_____

_____

_____

List all surgeries and hospitalizations:

Type of Surgery	Date	Reason for Hospitalization (other than listed surgeries)	Date

Are you allergic to anything? ___No ___Yes If yes, please list allergie:s _____

List all medications you have been prescribed (Prescription and over-the-counter)

_____

_____

_____

Are you currently out of any medications? ___Yes ___No

Highest grade completed in school:_____ Occupation: _____

_____

Patient Signature Date

Free Clinic of Meridian

Name (Please Print):_____

Date of Birth:_____

Privacy Practices Acknowledgement:

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it. I acknowledge that I understand the notice that has been provided to me.

Signature:_____Date:_____

Waiver of Liability:

I understand that the Medical Providers in the Free Clinic of Meridian have agreed to provide necessary medical care to me without compensation due to my inability to pay. I desire to be provided these services, and I am willing to waive my right to take legal action against the Medical Providers at the Free Clinic of Meridian for negligence that is not of either a willful or gross nature.

Signature_____Date_____

Consent to Treatment

I hereby request that a person authorized by the Free Clinic of Meridian provide appropriate evaluation, testing, and treatment (including a birth control drug or device if I request it). I also authorize the Free Clinic of Meridian to transfer my medical records at the request of other medical providers to ensure continuity of care when I have been elsewhere for medical services. I also understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

Signature:_____Date:_____

Free Clinic of Meridian

Authorization to Verify Patient Information

Name (Please Print)_____

Date of Birth:_____ Social Security #:_____

I hereby authorize the Free Clinic of Meridian to verify my income and availability of insurance by contacting my employer, my spouse's employer, the Mississippi Office of Medicaid, and/or the Office of Medicare.

I understand that having a household income above 200% of the Federal Poverty level for a household of my size or having any type of insurance will disqualify me from receiving care at The Free Clinic of Meridian.

_____ _____

Signature Date

Free Clinic of Meridian

HIPAA Contact Information Form

Persons authorized to receive my medical information:

(Include Full name, relationship, and phone number)

NAME:	RELATIONSHIP:	PHONE NUMBER

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

X _____ X _____

Printed Name Signature

DOB: _____ **Date:** _____

QUESTIONNAIRE FOR PATIENTS WITH NO INCOME

If you presently do not have any income coming into your household, please answer the following:

1. Has anyone in your HOUSEHOLD received income this month such as cash, checks, gifts? ___Yes___No
   If so, how much?_____

2. Have you received financial assistance through any of the following community agencies in the past three months?
   a. Multi-County ___Yes; _____Amount ___No
   b. Wesley House ___Yes; _____Amount ___No
   c. Salvation Army ___Yes; _____Amount ___No
   d. DHS/SSI ___Yes; _____Amount ___No

   If yes, what type of assistance did you receive?_____

   _____

3. Do you receive child support? ___Yes; _____Amount ___No

4. How are you paying your monthly bills? This includes rent, light bill, phone, gas, food._____

   _____