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| 4707 Poplar Springs Drive Meridian, MS 39305601-286-5551freeclinicofmeridian@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

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**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 lease 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!

**Free Clinic of Meridian**

**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

**For Office Use Only**

**\_\_\_Eligible \_\_\_Ineligible (Explain below) Name of reviewers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If ineligible, why? \_\_\_Insured \_\_\_Medicaid \_\_\_Medicare \_\_\_Under 19**

 **\_\_\_Above income requirements Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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** |
|  |  |  |  |
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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 |
|  |  |  |
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|  |  |  |
|  |  |  |

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

**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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you received financial assistance through any of the following community agencies in the past three months?
	1. Multi-County \_\_\_Yes; \_\_\_\_\_\_\_Amount \_\_\_No
	2. Wesley House \_\_\_Yes; \_\_\_\_\_\_\_Amount \_\_\_No
	3. Salvation Army \_\_\_Yes; \_\_\_\_\_\_\_Amount \_\_\_No
	4. DHS/SSI \_\_\_Yes; \_\_\_\_\_\_\_Amount \_\_\_No

If yes, what type of assistance did you receive?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you receive child support? \_\_\_Yes; \_\_\_\_\_\_Amount \_\_\_No
2. How are you paying your monthly bills? This includes rent, light bill, phone, gas, food.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_