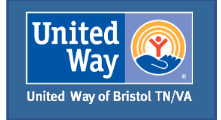
245 Midway Medical Park
Bristol, TN 37620
423-652-0260 ext, 272



Thank you for expressing an interest in becoming a patient of Healing Hands Health. ***We are a faith-based ministry providing healthcare to uninsured & underinsured residents of Northeast Tennessee and Southwest Virginia.***

Healing Hands Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

To become a Medical patient at Healing Hands Health:

- Patient does not have Private Medical Insurance, TennCare/Medicaid, Medicare
- Employment is not a requirement to become a medical patient

To become a Dental patient at Healing Hands Health:

- Patient does not have Private Dental Insurance OR
- Patient has Virginia Medicaid *(Employment is not a requirement to become a dental patient)*
  We are NOT currently accepting new TennCare dental patients. Please check back in May 2024.

To become a Vision patient at Healing Hands Health:

- Patient does not have Private Medical Insurance, TennCare/Medicaid, Medicare and/or Vision Insurance.
- Employment is not a requirement to become a Vision patient

Please complete in blue or black ink, and mail the application with copies of your supporting documentation to:

Healing Hands Health
245 Midway Medical Park
Bristol, TN 37620

Alternately, you can drop off your completed application with supporting documents to our Patient Enrollment desk (upstairs). We are open Monday through Friday from 8 am – noon, and 1 pm – 5 pm. We are closed on holidays and weekends. You can also apply online at https://healinghandshealth.org

Supporting Documents Needed:

1. **Photo ID**
2. **Copies of all health insurance cards (medical, dental, vision, and prescription)**
3. **Proof of Residency (an official piece of mail that shows your address, such as a utility bill)**
4. **Proof of Income (**total household income may not exceed 250% of the Federal Poverty Guidelines)
   a. **If you or your spouse are employed**: Please submit the most recent tax return for the household. (First two pages of the 1040 showing the Adjusted Gross Income.) OR bring 1 month of current paystubs for all working adults. (if they are paid weekly, bring the last 4 paychecks. If they are paid twice a month or every other week, bring the last 2 paystubs.)
   b. **If you or your spouse work but do not file taxes and do not receive paystubs, we need a Letter from Employer:** This letter must be on company letterhead with employer's contact information. Letter should state pay rate and number of hours worked in a week.
   c. **If you or your spouse receive Social Security benefits:** Award letters from Social Security Administration, VA benefits and any other pensions
   d. **If you or your spouse are Unemployed:** Official unemployment letter stating amount received each week
   e. **If you or your spouse are Self-Employed:** Bring your current tax return. (First two pages of the 1040 showing the Adjusted Gross Income and the Schedule C form) **AND** One month's worth of invoices and/or receipts from customers, showing you have received payments/income in the current year

YOUR APPLICATION TYPE	☐ New Patient Application	☐ Recertifying Patient Application

I, the undersigned, being of sound mind and body, do attest and confirm the following facts:

☐ I Am Uninsured. I have no medical, dental, or vision insurance coverage of any kind. **-OR-**

☐ I Have the following types of insurance (check all that you have):

☐Virginia Medicaid ☐~~TennCare~~ ☐Medicaid ☐Medicare ☐Medicare Advantage Plan ☐Medicare Supplemental Plan orDual Complete Plan ☐Medical Insurance from ACA ☐Private Medical Insurance ☐Private Dental Insurance ☐Private Vision Insurance

TYPE OF CARE NEEDED	☐ Dental	☐ Medical	☐ Vision

(Check all that apply.)

MY LEGAL NAME IS:

First Name: ______________________________

Middle Name: ______________________________

Last Name: ______________________________ Suffix (i.e., Jr. ,III, etc.): ____________

My Legal Gender: ☐ Female ☐ Male My Date of Birth (month/day/year): ____/____/____________

Social Security Number: ________-______-________ Email Address: ______________________________

MY PRESENT ADDRESS IS :

Address: ______________________________

City: ____________________ **State**: __________ **ZIP**: __________

MY HOUSEHOLD INCOME VERIFICATION:

The total number or individuals in my household:_________(use the *HOUSEHOLD Information on Enrollment Application p.2*)

☐ I have submitted all valid documentation required to verify my monthly household income.

MY INFORMATION:

Home Phone: (______) ____________________ Mobile Phone*: (______) ________________ Work Phone: (______) ____________________

*Can we text/leave messages on your Mobile Phone: ☐Yes ☐No

***How do you prefer to be contacted by us**: ☐Mobile Phone ☐Home Phone ☐Email (through our patient portal) ☐Mail

Preferred Language: ☐ English ☐ Spanish ☐ Other: ______________________________

Race: ☐ Black/African Am. ☐ Caucasian (white) ☐ Asian ☐ Other__________ ☐ *Decline*

Ethnicity: ☐ Hispanic/ Latina(o) ☐ Not Hispanic/ Latina(o) ☐ Decline

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Partner

Are You a U.S. Military Veteran?: ☐ Yes ☐ No **For Women, are you pregnant?** ☐ Yes ☐ No **How many weeks:** _______

Employment status: ☐ **Employed** ☐ **Unemployed** ☐ **Retired** ☐ **Disabled** ☐ **Student**

SIGNATURE: PATIENT AGREEMENT/DISCLOSURE: I attest that this information is true and accurate. I will immediately notify Healing Hands Health of any changes to my address, household income, or insurance status. I understand that in order to be a patient Healing Hands Health, I must comply with all requirements. If approved for medical care, I agree that Healing Hands Health will be my primary care physician. I understand that if I knowingly withhold information or provide false information, it may be grounds for permanent dismissal, and I will be responsible for any bills incurred. I give Healing Hands' staff permission to discuss and verify any and all information. I further give Healing Hands Health permission to share this information with Ballad Health if I am referred there for services.

I authorize and consent to the care and treatment provided by the healthcare professionals at Healing Hands Health as to be determined necessary in their professional judgment. I have the right to be informed of the nature and purpose of the treatment, and potential side effects thereof, as well as alternative treatment modalities, and the approximate estimated duration of my healthcare, and that I can withdraw my consent for treatment either orally or in writing whether prior to or during the indicated treatment period.

The below is my true and correct signature.

Print Name: ______________________________ **Signature:** ______________________________ **Date:** ____________

Enrollment Application, page 2

MY EMERGENCY CONTACT *The individual to contact, if needed.*

Emergency Contact Full Name: ____________________

Relationship to You: ☐ **Spouse** ☐ **Parent** ☐ **Child** ☐ **Sibling** ☐ **Friend** ☐ **Cousin** ☐ **Guardian** ☐ **Other***

*Other (please explain): ____________ Mobile Phone: (____)__________ Home Phone: (____)__________

HOUSEHOLD Information Worksheet : *This will help to determine your total household.*

We define your household as YOU and anyone listed on your tax return. **Count Yourself =1**

+ Count your spouse: ______+ Count all listed children: _____+ Count other listed dependents: ______

Add all together for your **TOTAL TAXABLE HOUSEHOLD = ______** *How many in the household receive Income?*_____

PROOF OF INCOME : *Provide all that apply for yourself and each individual in your household **

- ☐ Paystubs of the past 30 days
- ☐ Award letter of benefits from Social Security such as SSI/SSDI, SNAP, Retirement, Survivor benefits and pension, Veteran benefits
- ☐ Court Ordered Payments received such as Proof of Child Support and/or Alimony income your household receives
- ☐ Letter from Employer (on company letterhead) stating gross income, or an SHC Employee Verification form. *(if no paystubs)*
- ☐ Healing Hands Health Center Self Employment form listing one month of income and expenses. *(not needed if you have paystubs)*
- ☐ Award Letter for Unemployment Benefits
- ☐ HHHC Verification of Support form or a HHHC No Income Certification form if you are not working and not getting unemployment.

Note: If you have a spouse, you* ***must* *provide proof of income for you and your spouse. Additional documents may be required*

I HAVE BEEN ADVISED OF THE FOLLOWING:

☐ I have been advised by an HHH representative about documents I should submit to help the pharmacy at Healing Hands **provide me with reduced cost medications.** Documents include:

+My Most recent IRS Form 1040 (with schedule C, if applicable)

How Did You Hear About Us?

☐TV ☐Radio ☐Facebook ☐Web search/Website ☐Word of Mouth ☐Patient in Practice ☐Hospital ☐Event ☐Social Services ☐Another Medical Provider ☐Newspaper ☐Flyer/Card ☐Other:____________________

OFFICE USE ONLY

☐ **Approved and Active** ☐ **Approved Provisional Until: ____/____/________** ☐ **Declined**

Which Clinics:	Eligible through Date: ____/____/______	Monthly Income $__________	FPL: __________%	Number in Household

Documents	**Date**	**Initials**
Identification:		
Residency:		
Income:		
Consent Form:		
SSN/ITIN:		
IRS Forms:		

MEDICAID APPLICATION SECTION (required under 150% FPL)

Assisted with Medicaid App: ☐ Yes, on-site ☐ Yes, off-site ☐ Assisted by others (not HHHC)

Date of Medicaid Application: _____/_____/_________ ☐ Pt. certifies Not Eligible

Medicaid ID Number: ______________________________

Medicaid Application Status: ☐ Not Eligible ☐ Pending ☐ Approved/Active

Approver: ______________

Date: ______________

☐ **Special Exception:** *If boxed checked, application must be signed by Exec. Dir* or DO

Helen Scott/Corey Smith: ____________________ Date:____________

CLINIC GUIDELINES/ RULES

To provide you with the quality care you deserve, we ask that you do your part by agreeing to the following clinic guidelines.

Patient Care:

- Various volunteer physicians, dentists, specialists, nurses, dental assistants, medical assistants, hygienists, and students in training will be providing your care.
- Pre-doctoral or pre-hygienist clinic treatment is performed by student doctors and student hygienists under the direct supervision of an experienced University of Tennessee faculty dentist and ETSU faculty physician or hygienist.
- **Treating any provider with disrespect will result in an immediate dismissal from the program**.

Appointment Policy:

- *A* ***No-Show/Missed Appointment fee will be administered to patients who do not cancel their appointments within 24 hours*** *prior to the given appointment time.*
- The **No-Show fee will be $50 for missed dental appointments and $25 for all other missed appointments** including medical, dental hygiene, chiropractic, vision, and referrals to outside providers.
- We will attempt to contact you to remind you of your appointment time.
- It is your responsibility to provide our clinic with a working phone number and to update us with any new telephone numbers.
- If we cannot reach you to confirm your appointment and you do not call 24 hours prior to your appointment to confirm, your appointment will be given to the next deserving patient in need, and you will be responsible for the no show/missed appointment fee.
- **Patients who miss scheduled appointments will not be seen in the clinic again until the no-show penalty fee is paid in full.**
- **You may not bring an unsupervised child with you to your appointment. Please make childcare arrangements or the appointment will be canceled, and you will be charged a no-show fee.**

Patient Responsibilities:

- I understand that if I am a medical patient who needs medication assistance or Project Access, I may be asked to provide more information.
- I understand that I am responsible for any bills that may result from referrals to specialists or visits to the emergency room, urgent care, etc. I authorize Healing Hands Health to release the necessary medical records needed for any referral.
- I understand that if I give false information to any representative of Healing Hands Health, I will be dismissed from the clinic.
- We understand that having a health/dental issue is stressful, but all staff and volunteers are to be treated with respect, in person and phone calls. Failure to do so will result in your dismissal from the clinic; this includes, but not limited to foul language, threats, shouting, etc.
- Healing Hands ***does not provide narcotic pain management.*** We do not keep narcotics on the premises.
- I **agree to update my income documentation every year**.
- I agree to update my address and phone number when it changes.

- **You must advise the staff if you have any dental or medical insurance**
- Arrive on time to your appointments. Arriving 15 minutes or more late for your appointment may result in your appointment being rescheduled. As a courtesy, you may receive a reminder call, but not always. It depends on our staffing and the volume of patients. It is your responsibility to keep track of your appointments.
- **Give a 24-hour notice for cancelling appointments**. Failure to do so will result in a "No Show" fee that will have to be paid before scheduling another appointment.
- The value for a standard patient visit to serve your healthcare needs is $140. We charge our patients a small fee so we can continue to meet the expanding needs of our community. I understand that the following patient fees are due at the time of my visit:

  Medical $25
  Eyeglasses $25
  Dental $50
  Other Dental Procedures $100
  Eye Exam $20
  Dental Hygiene $25
  Medication Admin Fee $5/medication ($35 cap/visit)

Release:

- I give permission for my photo, interview, and/or comments to be used for marketing and fundraising purposes.
- I give permission for my x-rays or photos to be sent to other agencies associated with Healing Hands and/or to private doctors.

I certify that I have completely read the clinic guidelines above. I understand each statement and agree to follow these guidelines.

Signature of applicant: ____ **Date:** __________________

Consent to Share Healthcare Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communication or that communication be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Name: _________________________________Date of Birth: _________________________

Please indicate your preferred method of contact:

☐ Home Phone ______________________ May we leave a detailed message? Yes No

☐ Cell Phone _______________________ May we leave a detailed message? Yes No

☐ Work Phone ______________________ May we leave a detailed message? Yes No

May we discuss your medical condition with a family member or friend? Yes No
(If yes, please list their information below.)

I authorize Healing Hands Health to release my healthcare information to the person(s) listed below. I understand that the person(s) named on this authorization will be given access to obtain results/ information on my behalf. I authorize the person(s) indicated to pick-up materials pertinent to my medical care.

Name	Relationship to Patient	Telephone Number

Patient Signature: _________________________________Date: ________________________________

••

In lieu of patient signature, I, ______________________________________, as a staff member of Healing Hands Health, state that _______________________________has been provided with current Notice of Privacy Practices regarding how and who we can contact regarding their healthcare.

Staff Signature: ________________________________Date: __________________________________

Self-Employment Income/Expenses Record For Patient:

ONLY COMPLETE IF PATIENT IS SELF-EMPLOYED

Name: ______________________________ **Social Security #/** ITIN: ____________________

Month	Self-Employment-Monthly Income	Self-Employment- Monthly Expenses
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		
Total		

I certify that all the above income/expense information is true and correct.

____
Name of Applicant

______________________________ ____________________
Signature **Date**

Self-Employment Income/Expenses Record For Spouse:

ONLY COMPLETE IF SPOUSE IS SELF-EMPLOYED

Name: ______________________________ **Social Security #/** ITIN: ____________________

Month	Self-Employment-Monthly Income	Self-Employment- Monthly Expenses
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		
Total		

I certify that all the above income/expense information is true and correct.

____
Name of Applicant

______________________________ ____________________
Signature **Date**

VERIFICATION OF SUPPORT

ONLY COMPLETE THIS FORM IF A FAMILY MEMBER OR FRIEND IS HELPING SUPPORT YOU OR YOUR FAMILY

This form must be completed by the person who is helping support you and your family.

Name of Supporter: ___________________________________ Date: ________________

Address: ____

City: ________________________ State: ________________ Zip: _______________________

Phone Number of Supporter: ____

Check the type of support provided (check all that apply):

______ Food

______ Shelter

______ Financial Support (money given directly to applicant)

How much each month? $______

I declare that all information provided is true and subject to audit for verification purposes. I give Healing Hands Health permission to contact me to verify this information. I do not claim this person as a dependent on my tax return.

____________________________________ Supporter Signature

____________________________________ Patient Signature

______________________ Date

______________________ Date

NO INCOME VERIFICATION

ONLY COMPLETE IF YOUR HOUSEHOLD HAS ZERO INCOME

To be completed by applicant claiming zero household income from the following sources.

I certify that neither I nor any members of my household receive income from any of the following sources and do not receive support from family/ friends:

- Wages from employment (including commissions, tips, bonuses, etc.)
- Rental income from real or personal property
- Interest or dividends from assets
- Social Security payments, such as Supplemental Security Income, Social Security Disability Income, Retirement, Survivor's Benefits, annuities, insurance policies, pensions, or death benefits
- Unemployment
- Periodic allowances such as alimony, child support

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge.

Signature of Applicant: ________________________________ Date: _____________

Name of Applicant: ___________________________________

PROOF OF RESIDENCE

ONLY COMPLETE IF YOU CAN NOT PROVIDE A PIECE OF MAIL, PRINTED BILL, OR LEGAL DOCUMENT WITH YOUR NAME AND CURRENT ADDRESS

PATIENT'S NAME: ______________________________________

ADDRESS: ____

CITY: ____

STATE: ____

ZIP CODE: ____

NAME OF PERSON WHO OWNS OR RENTS THE HOME WHERE PATIENT LIVES:

____

HOW LONG HAS THE PATIENT LIVED AT THIS RESIDENCE?

____

______________________________________ ________________

SIGNATURE OF PROPERTY OWNER/ RENTER **DATE**

______________________________________ ________________

SIGNATURE OF PATIENT **DATE**