



Church Hill Free Medical Clinic
P.O. Box 166 · Church Hill, TN 37642
Phone: (423) 256-2408 · Fax: (423) 256-2426
Eligibility Information

Dear Patient:

Thank you for your interest in becoming a patient at the Church Hill Free Medical Clinic. The clinic is a faith-based clinic that provides free general medical care and Christian counseling to uninsured and underinsured residents of Hawkins County and the Tri-Cities community. We are able to provide these services because of the generous support from numerous donors, churches and volunteer staff.

To become a patient at the Church Hill Free Medical Clinic, you need to complete the enclosed application and bring it, along with the following documentation to your scheduled eligibility appointment or you may mail it, along with copies of the required information to the above address.

⇒ **Proof of Income**

- Copy of latest federal tax return
- Last two pay stubs from employer
- Proof of income from any other source for all household members

⇒ **Proof of Residency:** (At this time we do not have geographical limitations, but are in the process of developing boundaries for our service areas. Please bring on of the following to show where you live:

- Copy of utility bill such as a phone bill, water bill or a power bill

⇒ **Insurance card or documentation of insurance if you have insurance**

⇒ **Proof of Identification:**

- Driver's License or Student ID

Eligibility Appointments: New applications will be processed on the following days at the Church Hill Free Medical Clinic:

- Date and Time has not been determined yet; in the meantime, you may mail the application back to the office at the above address.

Patients must have household income that fall within our eligibility guidelines, which are listed on the back of this letter. If your income is more than our guidelines permit, but you are experiencing a financial hardship, you are welcome to request a hardship application. Your request will be reviewed by a committee of three board members and you will be notified of their decision to accept or not accept you as a patient within 3 weeks after applying. Although this committee will be told of the circumstances surrounding your hardship, your name remains anonymous to these committee members.

If you have any questions or need further information, please contact us at 423-256-2408 on Tuesdays or Thursdays from 10 a.m. – 5 p.m.

CLINIC ELIGIBILITY GUIDELINES

185% U.S. Poverty Guidelines

July, 1, 2007 – June 30, 2008

Number of Persons in Household	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	18,889	1,575	788	727	364
2	25,327	2,111	1,056	975	488
3	31,765	2,648	1,324	1,222	611
4	38,203	3,184	1,592	1,470	735
5	44,641	3,721	1,861	1,717	859
6	51,079	4,257	2,129	1,965	983
7	57,517	4,794	2,397	2,213	1,107
8	63,955	5,330	2,665	2,460	1,230
For Each Additional Family Member Add	6,438	537	269	248	124



Church Hill Free Medical Clinic Patient Eligibility Application

General Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Work or Cell Phone: _____

Gender: Male Female **Race:** White Black Hispanic Other

Are you? Single Married Widowed Divorced Separated

Number of ADULTS (age 18 or older) living in household (including yourself): _____

Number of CHILDREN under 18 living in your household: _____

Emergency contact person: _____ Relationship to you: _____

Emergency contact phone number(S): _____

Health Insurance Information:

TennCare/Medicaid: Yes No Veteran's Benefits: Yes No

Medicare Part A: Yes No Medicare Part B: Yes No

Medical Insurance: Yes No Dental Insurance: Yes No

Workman's Comp: Yes No Applying for SS: Yes No

1. Do you have a deductible on your insurance? Yes No

2. If yes, how much is your deductible? \$ _____

3. If you have insurance, do you pay a co-payment for office visits? Yes No

4. If yes, how much is your co-pay for an office visit? \$ _____

5. If you have insurance, do you have prescription coverage? Yes No

6. Do you pay a co-payment for medication? Yes No

7. If yes, how much is your co-pay for insurance? \$ _____

(Please complete the information on the back of this form)

Other Information:

Are you currently seeing a private doctor? Yes No

Doctor's name: _____ Date of Last Visit: _____

Employment Information:

I am: Employed Employer: _____ Occupation: _____

Unemployed Date you became unemployed: _____

Student Name of school: _____

Retired From: _____ Date of Retirement: _____

Spouse/Significant Other/Other adult household member:

List Name: _____ Age: _____

Employed Employer: _____ Occupation: _____

Unemployed Date unemployment started: _____

Student Name of school: _____

Retired From: _____ Date of Retirement: _____

Gross monthly income (before taxes):

Your Income:

Spouse/Significant Other/Other Adult's Income:

Employment:	Employment:
Social Security:	Social Security:
Disability:	Disability:
Unemployment:	Unemployment:
Child Support:	Child Support:
Families First:	Families First:
Other Public Assistance:	Other Public Assistance:
Other Income:	Other Income:
Total Income:	Total Income:

Current Year Total Household Income: \$ _____ (based on last 2 pay stubs)

Previous Year's Total Household Income: \$ _____ (based on federal tax return)

I certify that all information given is true and complete. I understand that if I have given false information or withheld information I may no longer be eligible for services at the Church Hill Free Medical Clinic.

Applicant's Signature: _____ **Date:** _____