125 Russell Parkway
Warner Robins, GA 31088

Phone: 478-923-9730
Fax: 478-923-5515

APPLICANT NAME: ______________________________ **DATE:** ________________________

Eligibility Guidelines:

- You must be 18 to 64 years of age and provide a Driver's License/picture ID with birthdate AND Social Security card
- You or your spouse must be employed and provide proof of employment (Current 1040 income tax return and one month worth of pay stubs and any other income received) (If self-employed, must provide current W-2 and 1099 forms)
- You must live in Houston County and provide proof of residency.
- You must be uninsured meaning you are not covered by health insurance (private or employer paid) or Medicare or Medicaid and provide proof (Letter from your employer and letter from spouse employer, if applicable.)
- Your family gross income must be less than 200% of the 2024 Federal Poverty Level. Family means the individual, his/her legal spouse, the other parent of his/her children, and all his/her minor children (18 and under) living together. A person who is temporarily living away from his/her family due to job, school, hospitalization, or similar circumstances is considered a family member.
  PLEASE CIRCLE APPROPRIATE HOUSEHOLD SIZE.

Household Size	Annual Income Limit	Monthly Income Limit
1	$30,120	$2,510
2	$40,884	$3,407
3	$51,636	$4,303
4	$62,400	$5,200
5	$73,164	$6,097
6	$83,916	$6,993
7	$94,680	$7,890
8	$105,444	$8,787

For families with more than 8 people, add $897 to annual income for each additional person.

Patients must be screened for eligibility before receiving an appointment to see a physician. ALL of the following documents must be provided:

_____Picture ID
_____Social Security Card
_____Letter from your employer stating you are employed and have no health insurance
_____Letter from your spouse's employer stating you are not covered under their insurance
_____If self-employed, provide most current W-2 and 1099 form
_____Current year's 1040 tax return for you and your spouse
_____One month worth of current pay stubs and any other income received
_____Utility bill with your name and address showing proof of Houston County residence

Please call 478-923-9730 if you have any questions about eligibility or unusual circumstances.

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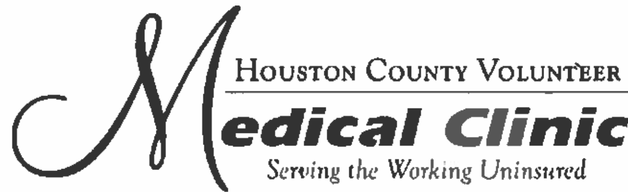
Patient Responsibilities

- Provide all eligibility documentation at the time of application. We cannot enroll you or make an appointment with the doctor until all documents are received.
- Be courteous to all our staff and volunteer health care providers. Almost everyone is donating their time and services to make a difference in your health and well-being. You cannot request a particular clinic physician unless your diagnosis or illness warrants it. Our physicians' schedules vary each month.
- Keep all scheduled appointments. If you are unable to keep your scheduled appointment for any reason, you must provide a 24-hour notice when cancelling or rescheduling. Two **no shows/missed appointments** may warrant discharge from our services.
- Each year you must complete a recertification packet and provide us with updated eligibility documentation. **Recertification deadline is April 30th of each year to continue services including prescription refills.**
- Commit to meet the health goals and objectives set forth in your treatment plan. We will discuss these with you and our desire is for you to be as healthy as possible and enjoy living. Please do not hesitate to talk to us if you are having difficulties meeting your goals.
- **Always provide and maintain an active phone number on file, that accepts messages if you are unavailable. We must have a way to contact you or leave a message.**
- Request prescription renewals/refills during your doctor visits. You are responsible for knowing when your refills are due.
- Notify us if you get or plan to get insurance/Medicaid. We will accommodate a transition of care visits if medically necessary.
- You will be financially responsible for the following services:
  - ✓ Emergency Room/Urgent Care services.
  - ✓ Prescriptions filled at local pharmacies.
  - ✓ Private physician appointments.
  - ✓ Labs or procedures at any other hospital other than Houston Medical or Perry Hospital. You must have a referral from Houston County Volunteer Medical Clinic to avoid charges.

I certify that the information I have provided for eligibility is complete, true, and correct.
I have read the above and agree to my responsibilities as a patient. If I choose not to adhere to these responsibilities, I understand that I will/may be discharged from Houston County Volunteer Medical Clinic and may not be eligible for further care.

Signature ______________________ **Date:** ______________



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Authorization of Release of Information

*****Signature only at the bottom of page*****

I hereby authorize the Houston County Volunteer Medical Clinic (HCVMC) to release or disclose to:

Name: ______________________________
Address: ______________________________
City: ____________ State: ________ Zip: ____________

Complete the section below to request information from a physician, hospital, or clinic to be sent to the Houston County Volunteer Medical Clinic.

I hereby authorize:

Name: ______________________________
Address: ______________________________
City: ____________ State: ________ Zip: ____________

To release or disclose all medical information to the Houston County Volunteer Medical Clinic.

All medical records or other information regarding my treatment, hospitalization, and/or patient care including psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV), including acquired immunodeficiency syndrome (AIDS), or tests for HIV, or sexually transmitted diseases.

I authorize the use of a fax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization will remain in effect until withdrawn. I further understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. I also understand that, should I decide to revoke my consent to obtain or release information, HCVMC may dismiss me from membership if lack of information hinders the ability of health care professionals to successfully treat my health condition(s). I further understand that I have a right to copy of this authorization upon request. This agency, its employees, volunteers, and all affiliates, including all physicians and hospitals are hereby released from any legal responsibility or liability for disclosure of information to the extent indicated and authorized.

______________________________ ____________________

Signature **Date:**

125 Russell Parkway
Warner Robins, GA 31088

Phone: 478-923-9730
Fax: 478-923-5515

Notice to Applicant

As an applicant and a potential participant in Houston County Volunteer Medical Clinic (HCVMC) you must read and sign the Certification, Authorization of Release of Information, and Participation Agreement before you can receive services from HCVMC. If there is any portion of the information that you do not understand, please ask the HCVMC screener for an explanation.

Certification

I certify that the information provided in this application is accurate and true to the best of knowledge. I understand that if I give false or misleading information I will be prohibited from participation. I understand that even if my application is approved, provision of services cannot be guaranteed. By my signature on this form, I release Houston County Volunteer Medical Clinic, Inc. (HCVMC) from liability pursuant to any service I receive from HCVMC.

Authorization to Release Information

I give my consent for the necessary departments to advise HCVMC of the status of any pending Medicaid, clinic care, GPCF, or HCCG application for myself and/or my family. HCVMC has the authority to make final decisions for all applications.

Participant Agreement

I understand that I must:

- Not have a total family income that exceeds 200% of the federal poverty line.
- Maintain a Houston County residency.
- Not have insurance of any type.
- Give my consent for HCVMC to obtain necessary documentation that my family and I meet HCVMC eligibility requirements.
- Cooperate with HCVMC patient responsibilities and requirements.

I acknowledge that I have read and understand the information provided to me.

______________________________ ______________________

Signature Date:

Houston County Volunteer Medical Clinic

Date:

Patient Information (Please print clearly)

Patient's Legal Name:	Social Security No:	Date of Birth:	Age:	Race:
Ethnicity: o non-Hispanic o Hispanic or Latino o Other: ____________ Number of members in your household:				
Preferred Language:	E-Mail Address:			
Patient's Home Address: Street City State Zip				
Primary Phone Number:	Second Phone Number:	Cell Phone Number:		
Marriage Status: oSingle oMarried oSeparated oDivorced oWidowed	School grade/education level finished?			
Employment Status o Full-Time o Part-Time oRetired oActive Military Duty	Occupation/Title	How long Employed?		
If employed, do you work: o Days o Nights o Evenings	May we contact you at work? o Yes o No	Best time to contact you?		
Employer's Name and Address: Street City State GA				
Have you ever been a patient here before? If so, what was your name?				

Spouse's Information

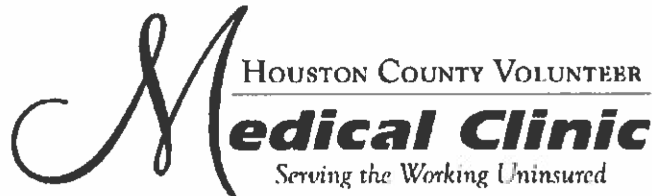
Spouse's Legal Name:	Social Security No:	Date of Birth:	Race:
Primary Phone Number:	Second Phone Number:	Cell Phone Number:	
Employer's Name and Address: Street City State GA			
Employment Status oFull-Time oPart-Time oRetired oActive Military Duty	Occupation/Title	How long Employed?	

Emergency Contact is required:

Name:	Primary Phone Number:	Relationship to Patient:

Next of Kin

Name:	Primary Phone Number:	Relationship to Patient:



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.
Federal law to require Houston County Volunteer Medical Clinic (HCVMC) to:

- Maintain the privacy of your protected health information.
- Provide you with this Notice of Privacy Practices.
- Abide by the terms of this Notice; and
- Change the Notice only as it states it will do.

Under Federal Privacy Regulations you have the following rights:

- Right to receive a copy of this notice.
- Right to request restrictions on certain uses and disclosers, though HCVMC is not required to agree to such restrictions. If HCVMC is willing to accept such restrictions, additional statement concerning its duty to honor such restrictions and the process for terminating the restriction will be provided.
- Right to receive confidential communication from HCVMC
- Right to inspect and copy your own Protected Health Information
- Right to receive an accounting of disclosure of Protected Health Information
- Right to review this Notice of Privacy Practices before signing any consent
- Right to authorize uses and disclosure of information for all other purposes, subject to the exceptions created by HIPAA Privacy Standards.
- Right to appeal denials of access to your own information to HCVMC except in certain circumstances
- Right to amend incorrect or incomplete information. If the amendment is denied, you have a derivative right to protest the refusal to amend, as well as to require the protest to be attached to all future disclosure of the information.
- Right to file a complaint with HCVMC if it fails to follow the requirements of the Privacy Standards.
- Right to opt-out of disclosure of information to facility directories (including disclosure to clergy) or to family members of other to file a complaint who may be assisting with care.
- Right to file a complaint with the Secretary of the Department of Human Services if you believe privacy rights have been violated. You should direct the complaint to:

Office of Civil Rights: ATTN: Privacy
U.S. Department of Health and Human Services
200 Independence Avenue, Room 509F
Washington, D.C. 20201
Email address: ocrprivacy@hhs.gov

HCVMC conducts a program in cooperation with certain health care and other entities including Houston Healthcare, and Houston Co. Health Department. HCVMC purpose is to provide health care to the working uninsured who meets the eligibility requirements of the clinic. To perform this function, it is necessary for HCVMC to disclose personal, financial, medical, and utilization information along with other Protected Health information to the above and other entities.

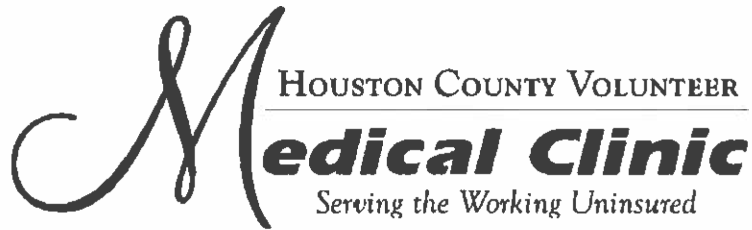
HCVMC may use your Protected Health Information for or incident to your treatment in the health operation of HCVMC. Treatment may include primary care for acute or chronic disease, the ordering of laboratory and/or radiological studies, or subsequent referral to a specialist for specialty care, and in some cases these users will require HCVMC or its affiliates to share information obtained in rendering services to you with one or more of its affiliates. To establish eligibility, HCVMC will ask for documentation of payment information which includes financial and household income information, source of payment, payment plan arrangements and the like and will be transmitted or shared incidents to your treatment and referral. HCVMC does not charge for health care services. Business operations include information about diagnosis, treatment, payment, and certain activities, such as utilization quality assurance review. HCVMC might also share your personal health information incident to its tracking of certain physical conditions and illness. Further information on your rights pursuant to this Notice of Privacy Practices can be found at 42 CFR & 164.520 "Notice of Privacy Practices for Protected Health Information."

For more information or to file an internal complaint, contact the NSA director at (205)327-8254. This NPP may be amended by action of the Board of Directors of HCVMC in its discretion as it determines necessary.

I acknowledge that I have read and understand the information provided to me.

______________________________ ______________________

Signature Date:



Income Attestation Form

Patient's Name:	Social Security Number:
Number of Legal Dependents in Household, including Spouse:	

	(If Applicable)
Patient's Employer:	Spouse's Employer:
Patient's Address:	Spouse's Address:
Patient's Job Title:	Spouse's Job Title:
Patient's Length of Employment:	Spouse's Length of Employment:
Patient's Business Phone:	Spouse's Business Phone:
Patient's Hourly Rate:	Spouse's Hourly Rate:
Patient's Monthly Income Gross:	Spouse's Monthly Income Gross:

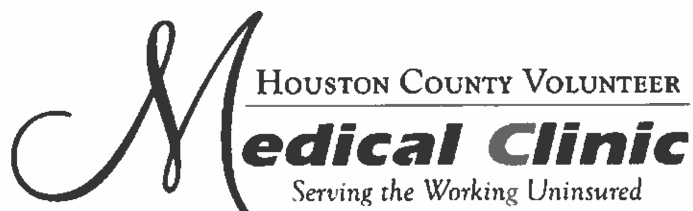
Other Income Source/ Amount:	Total Family Monthly Gross Income:

Have you applied for Medicaid or any other State/County Assistance? ________Yes _______No
Approved/Denied letter ________________________

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I hereby certify that as to the hospital charges for which I am asking for an Uninsured Charity discount, I am not currently eligible for any third-party health benefits, which may include but not be limited to Medicare, Medicaid, private health insurance or a self-funded employer-sponsored health benefit plan. I understand the information submitted is subject to verification. I grant permission and authorization for an authorized agent of HCVMC to follow up and very on any information provided on this form for the purposes of making an Uninsured Charity discount determination.

________________________________ ________________

Signature ________________________ Date ____________



HIPAA Communication Form

Patient Name: ______________________________

Date of Birth: __________

I grant permission for Houston County Volunteer Medical Clinic to send mail to the following address:

Address: ______________________________
City: ____________________ **State:** ______
Zip Code: __________

I grant permission for Houston County Volunteer Medical Clinic to call me at the number(s)/email(s) checked below:

- ☐ Home Phone: ______________________________
- ☐ Work Phone: ______________________________
- ☐ Cell Phone: ______________________________
- ☐ E-mail Address: ______________________________
- ☐ Text, okay? Yes/No: ____________________

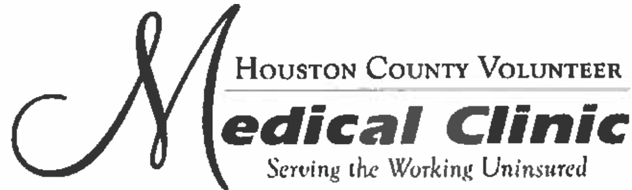
Who does Houston County Volunteer Medical Clinic have permission to speak with at your phone number(s)? Please check all that apply:

- ☐ Permission granted to speak with anyone who answers the phone.
- ☐ Permission granted to only speak with spouse –
  Name: ______________________________
- ☐ Permission to speak with: ______________________________
  Relation: ____________________
- ☐ Permission NOT granted to speak with anyone except myself.

Leaving a message on the phone, please check all that apply:

- ☐ May leave any message.
- ☐ May identify yourself and leave a call back number.
- ☐ Do NOT leave any message on my answer machine/voicemail.

______________________________ ____________________
Patient Signature Date



Limited Power of Attorney for Medication Assistance

I authorize employees of the Houston County Volunteer Medical Clinic a 501(c) 3 non-profit organization to act on my behalf and sign applications and documents on my behalf for medication assistance, and I hereby grant to Houston County Volunteer Medical Clinic, INC my Limited Power of Attorney for this purpose and this purpose only. I understand that I may revoke this Limited Power of Attorney at any time by providing written Revocation to Houston County Volunteer Medical Clinic at 125 Russell Parkway, Warner Robins, GA 31088.

I authorize the physicians or other medical provider's office to discuss and 'or release my protected health information (PHI) to Houston County Volunteer Medical Clinic to facilitate the processing of my application for medication assistance. I understand that this authorization will be valid until a written revocation of this authorization is received.

I understand and acknowledge that each pharmaceutical company has the exclusive right to decide whether I qualify for their prescription assistance program, and that the Houston County Volunteer Medical Clinic does not guarantee or warrant that I will receive the medications for which organization may apply on my behalf.

I understand the application processing may require a period of several weeks. I acknowledge that either Houston County Volunteer Medical Clinic, INC. nor any pharmaceutical manufacturer nor any affiliated provider is responsible for any adverse health effects that may result due to any decision on my part to delay acquiring and taking medications which have been prescribed for me until my medication assistance application has been processed, and I further acknowledge that the Houston County Volunteer Medical Clinic does not advise such delay.

____ ____________________

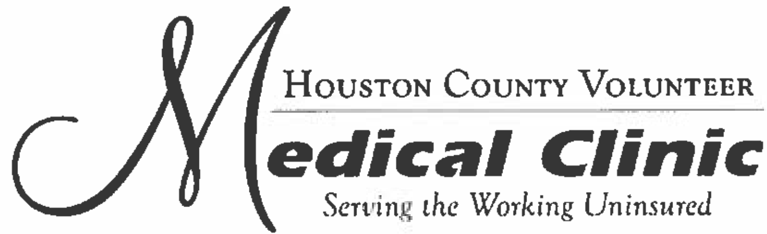
Signature of Applicant Granting Limited Power of Attorney Date

____

Printed Name of Applicant Granting Limited Power of Attorney

____

Signature of Representative for Applicant (if applicable)



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Employer Verification Letter

This letter is to verify that ______________________________ is employed part-time/full-time (circle which one applies) by ______________________________ (business/employer name) and is not receiving medical health insurance for the following reason(s) (check all that apply):

- Health Insurance is not offered
- Employee does not qualify
- Employee refused insurance coverage

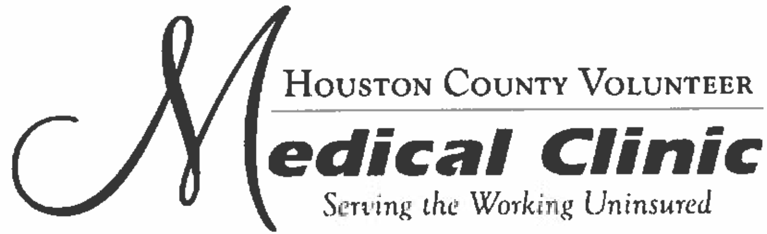
Business/Employer (print): ______________________________

Supervisor Name (print): ______________________________

Supervisor Signature: ______________________________

Phone Number: ______________________________

Date: ______________________________



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Spouse Employer Verification Letter

This letter is to verify that ______________________________'s **spouse**

____________________________ (**employee name**) is employed part-time/full-time (circle which one applies) by ______________________ (business name) and neither are receiving medical health insurance for the following reason(s) (check all that apply):

- Health Insurance is not offered
- Employee does not qualify
- Employee refused insurance coverage

Business/Employer (print): ______________________________________

Supervisor Name (print): ____

Supervisor Signature: ____

Phone Number: ____

Date: ____