HOUSTON COUNTY VOLUNTEER
Medical Clinic
Serving the Working Uninsured

125 Russell Parkway
Warner Robins, GA 31088

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

Dear Patient:

As a patient of the Houston County Volunteer Medical Clinic, we require written verification of your household income **every year**. Partial/incomplete documentation **will not** be accepted.

Please note: If you have insurance or Medicaid stop here and notify the clinic.

Please provide us with all the following:

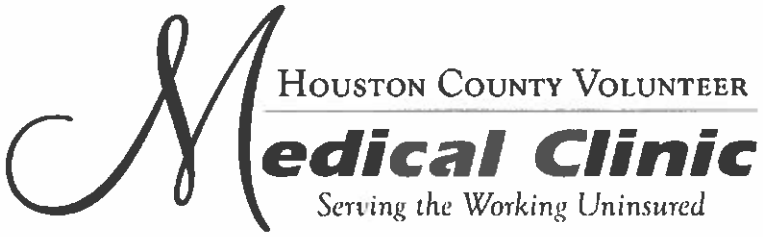
- All household income
  Current year's completed 1040 Federal income tax return or 1099 form if self-employed. Tax return must include you and your spouse, if you are married, and any children in your household.
  ---AND—
  One month of the most recent pay stubs for you and your spouse (if applicable)
- Verification from your employer and your spouse employer (if applicable) that you do not have insurance.
- Updated Patient Information with current contact information
- Updated HIPAA Communication Form
- Updated Limited Power of Attorney for Medication/Prescription Assistance

Sometimes we can get your prescriptions filled through our Prescription Assistance Program FREE, NO CHARGE to you. If so, we may have to request your 1040 Federal income tax return. Or, if you do not file taxes, we will need for you to fill out a 4506-T form. We will notify you if these forms are necessary.

For us to continue to meet your needs by providing FREE healthcare services, the above information must be received in our clinic by **June 30th.** You can drop it by, fax it to us (478-923-5515) or email it to info@hcvmc.org.

Please help us continue meeting your healthcare needs. If you have any questions, please contact us at the Clinic **(478) 923-9730.** On behalf of the Volunteer Medical Clinic staff, thank you for your assistance in helping us serve you.

Sincerely,
Houston County Volunteer Medical Clinic



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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: _____

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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. 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 in order 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 or which organization may apply on my behalf.

I understand the application processing may require a period of several weeks. I acknowledge that neither 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(s) have 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)

_____ Witness

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Updated Patient Information Date_____

Patient's Name_____

Home Phone_____ Cell Phone_____

(Must provide a working number that accepts messages if you are unavailable.)

Email_____

Please circle your preferred method of contact: Phone message, Text Message, Email

Address_____

City_____ State_____ Zip Code_____

Date of Birth_____ Age_____ Gender_____

Social Security Number_____

Preferred Pharmacy/Location_____

Religious Preference_____

Spouse's Name_____

Spouse's Date of Birth_____

Spouse's Social Security_____

Spouse's Employer_____

Spouse's Work Number_____

Spouse's Work Address_____

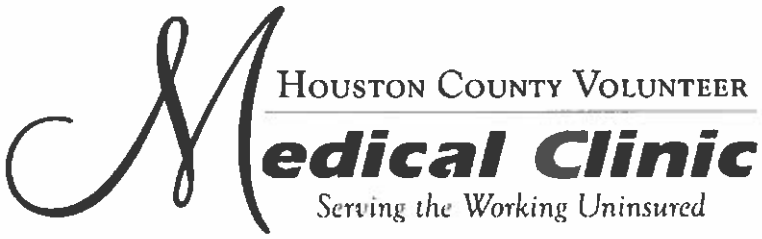
Spouse's Occupation_____

Nearest relative, neighbor, or friend NOT living with you (in case you cannot be reached):

Name_____

Phone_____

Address_____



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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/text me at the number(s)/email(s) checked below. Please check all that apply:

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

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