Healing Hands Health Center

245 Midway Medical Park
Bristol, TN 37620
Phone: 423-652-0260 Fax: 423-573-0694
www.healinghandshealthcenter.org

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

To become a Medical, Vision and/or Chiropractic patient at Healing Hands Health Center:

1. Patient does not have Private Medical, TennCare/Medicaid, Medicare and/or Vision Insurance.
2. Patient and/or someone living in your home must be employed or have worked in the last 12 months, unless they are retired or a student.

To become a Dental patient at Healing Hands Health Center:

1. Patient does not have Dental Insurance.
2. Dental services are also provided to individuals who have been declared legally disabled and draw Social Security benefits.

Please complete the application on the other side in blue or black ink, and bring the documentation listed below to one of the designated enrollment days. If you do not have all of the required documentation with you at the time of the interview, you will be asked to return on another enrollment day.

The following enrollment times are first come first served:

Monday	2:00 pm – 4:00 pm
Tuesday	4:00 pm – 6:00 pm
Wednesday	10:00 am – 12:00 pm
Thursday	4:00 pm – 6:00 pm

You will need to bring the following documents to the Enrollment Interview:

1. Your Photo ID
2. Your Social Security Card
3. Proof of Income – total household income may not exceed 250% of the Federal Poverty Guidelines
   Either you and/or someone living in the home, will need to provide ONE of the following documents as Proof of Income:
   A. **1 month of current paystubs** - For example: if you are paid weekly, you will need to show 4 paystubs; if you are paid bi-weekly, you will need to bring 2 paystubs). If you file a tax return, please bring your most recent 1040 form as well.
   B. **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. **Social Security:** Award letters for social security benefits, VA benefits and any other pensions.
   D. **Child Support:** if you receive child support, please bring documentation.
   E. **Unemployment letter:** Official unemployment letter stating amount received each week.
   F. **Self-Employed:** You MUST provide one of the following:
      a. Current tax return: First two pages of the 1040 showing the Adjusted Gross Income and Schedule C.
         OR
      b. Invoices and receipts from customers, showing you have received payments/income in the current year.
   G. **Student**: students who are not working must provide their current class schedule

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APPLICANT INFORMATION

Last Name:	First Name:	MI:
Date of birth:	SSN:	Phone:
Current Address:		
City:	State:	ZIP Code:
Gender: Male ❑ Female ❑	Marital Status: Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑	
Race: Caucasian ❑ African American ❑ Hispanic ❑ Other ❑	Are you a Veteran? Yes ❑ No ❑	

EMPLOYMENT INFORMATION

Current Employer:	Position:	
Employer address:	City:	
State:	Zip:	Phone:
Are you: Unemployed ❑ Date Unemployment started:		Disabled ❑
Retired ❑ Date retirement started:	Student ❑ Name of school:	

HEALTH INSURANCE INFORMATION

Providing false information will result in dismissal from the clinic

Do you have insurance? Yes ❑ No ❑

If you do have insurance, circle all that apply: Medical Dental TennCare Medicaid Veterans Benefits Medicare

Have you been declared legally disabled: Yes ❑ No ❑

INFORMATION OF PEOPLE WHO LIVE WITH YOU

NAME	AGE	RELATIONSHIP	DATE OF BIRTH	DOES THIS PERSON WORK?

SIGNATURE

The information I have provided on this form is true and accurate to the best of my knowledge. I understand that Healing Hands Health Center provides care to those individuals who qualify for services under the Center's guidelines. I understand that if I am accepted for care at the center, I agree to follow all the Center regulations and guidelines.

Signature of applicant:	Date:

United Way of Bristol

This project is funded under an agreement with the State of Tennessee and the Commonwealth of Virginia.

Current Medication List

Name: ____________________ Date of Birth: ______________

Medication Name & Dose	How often do you take it?	How long have you been taking it?	If you are out of it, how long have you been out?
Example: Zocor 40 mg	Once a day	6 months	1 month, 2 days, etc.