HANDS of HOPE CLINIC
1010 Hospital Drive, Building B, Stockbridge, GA 30281
Phone: (770) 507-1344 Fax: (770) 507-1377
www.handsofhopeclinic.org

Applicants must provide **ALL** required documentation at once. You must recertify annually. We cannot schedule any appointments or refill any medications until certification requirements are met.

**Hours of Operation for New Patient Enrollment:**
By Appointment Only- **Walk-ins not accepted**
Call 770-507-1344, Option 4, to schedule.

**DOCUMENTATION REQUIREMENTS:**

_____ Proof of **Henry County Residency**: A VALID Georgia ID card or driver's license

_____ Most recent federal tax return
If you do not file taxes, you must provide a copy of your prior two years' tax transcripts (Form 4506-T), which can be retrieved at www.irs.gov.

_____ Current bank statement

_____ Proof of income: You must provide *TOTAL Household Income* (income from ALL wage earners living in your household or providing your basic living resources).

- Employed – Most recent pay stubs for past 4 weeks.
- Unemployed – Quarterly wage report from GA Dept of Labor*
- Self-employed – Quarterly wage report from GA Dept of Labor* and current profit or loss statement must be included for all self-employed members of the household, and all forms and schedules filed.
- **THIS INCLUDES SOCIAL SECURITY, MILITARY PENSION, ETC.**

_____ Medicaid denial letter

- Apply at the DFCS office OR
- Apply online at gateway.ga.gov/access/
  (Print the page that says "Congratulations! You've submitted your application!")

***GA DEPT OF LABOR LOCAL OFFICES:**

1630 Phoenix Blvd.
College Park, GA
678-284-0200

1514 GA Hwy 16
Griffin, GA
770-228-7226

**PATIENT FEES (Cash Only):**

**Primary Medical**: New patient first visit: $50.00
Follow up visits: $20.00

**Dental:** No charge for treatment. Lab fees may vary. All fees will be discussed prior to treatment.

**Specialist Visits**: $40.00

**Mental Health**: No charge

**Prescription Assistance Plan Enrollment:** $10.00 per application, not to exceed $30.00.

*We do not treat those with Medicaid, Medicare, VA benefits, or private insurance. *

HANDS of HOPE CLINIC

**Patient Information**- Please complete all sections and print clearly

**Name:**_____
First Middle Last

**Date of Birth:**_____/_____/_____ **Social Security #**_____-_____-_____

**Street Address:**_____

**City**_____ **State** _____ **Zip Code**_____ **County of residence:** _____

**Home Phone (**_____)-_____-_____ **Cellular Phone (**_____)-_____-_____

**E-Mail Address:**_____

**Gender** _____Male _____ Female **Ethnicity** _____ Hispanic _____ Non-Hispanic

**Race** _____ White _____ Black _____ Asian/ Pacific Islander _____American Indian

**Marital Status:** ___Single ___Married ___Divorced ____Widowed ___ Legally Separated

**Number of children under 18 (21 if enrolled in college full time)** :_____

**Employer:**_____ **Occupation:**_____

**I have:** ____ Medical Insurance ____Vision Insurance ____ Dental Insurance

____ Ga Medicaid ____ Ga Medicare

**How did you hear about us? (Please circle one and specify)**

Hospital* - Primary Care Physician* - Specialist Physician* - Advertising - Word of Mouth -

Patient in the Practice - Insurance Company - Other

*Please specify Hospital or Physician: _____

Are you applying for treatment at Hands of Hope Clinic because you lost your employment or insurance (Private insurance or that provided by your employer) as a direct result of Covid-19?

_____YES _____NO

If yes, please explain the impact which caused you to seek treatment with Hands of Hope Clinic.

_____

_____

_____

**(OVER)**

**Emergency Contact:** _____

**Relationship**_____ **Phone # (**_____**)-**_____**-**_____

I certify that the above information is true and complete to the best of my knowledge. I understand I will be treated by volunteer Doctor, Physicians Assistant or Registered Nurse Practitioner on a priority basis and not personal preference. I understand that as a patient I may be discharged from the clinic for failure to comply and must obey the clinics guidelines. By signing this I am acknowledging I have received a copy of my rights and responsibilities.

**Signature of Patient**_____ Date____/____/____

HANDS of HOPE CLINIC

## Patient Financial Eligibility Form

**Name:**_____
Last First MI

**Street Address:**_____

**City**_____ **State**_____ **Zip Code**_____ **County of residence:** _____

**Home Phone** (_____)_____-_____ **Cellular Phone** (_____)_____-_____

**Date of Birth:**_____/_____/_____ **Gender** ____Male ____ Female **Ethnicity:** □ Hispanic □ Non-Hispanic

**Race:** □ Black □ White □ Asian/Pacific Islander □ Hispanic/Latino □ Native American □ Other

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

**Family Size:** Adults_____ Under 18_____ 18-21 Student_____ Family Size TOTAL:_____

**Religious Affiliation:**_____ **Church (if applicable):**_____

PATIENT ACKNOWLEDGEMENT:

I hereby certify that the above information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge. I authorize examination, diagnostic procedures and treatment as deemed necessary by the doctor(s) or other health care professional(s) (and whomever he/she may designate as assistants). I also acknowledge that failure to provide Hands of Hope with an update on financial or health insurance status upon change to this status may result in my inability to receive health and/or dental care. I understand that as a patient I may be discharged from the clinic for failure to comply and must obey clinic guidelines. By signing this, I am acknowledging that I have read and understand the Notice provided in this section and that I have received a copy of Hands of Hope clinic policies.

Please initial here: _____

I give permission to Hands of Hope Clinic staff and/or a volunteer representative to leave a message on voicemail regarding treatment, prescriptions and/or any other pertinent Clinic information that needs to be relayed.

Please initial here:_____

_____ _____ _____
Signature of Patient Printed Name of Patient Date

_____ _____ _____
Signature Staff/Volunteer Printed Name Staff/Volunteer Date

***Please see other side***

## FINANCIAL ELIGIBILITY

**Do you have insurance (Health/Vision/Dental), GA Medicaid or Medicare?** ☐ Yes ☐ No

If you checked "No," your income must be at or below 300% of the Federal Poverty Level to be eligible to receive services at Hands of Hope Clinic. Gross Family earned/unearned monthly income: $_____

| Family Members Name | Date of Birth | Gross Earned Income Last 4 Weeks | Gross Unearned Income Last 4 Weeks |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | TOTAL INCOME | $ |
| | | TOTAL ANNUAL INCOME | $ |
| | | INCOME LEVEL | % |

HANDS of HOPE CLINIC

# PATIENT ACKNOWLEDGEMENT OF CLINIC POLICIES

Patient Name:_____, _____, _____ DOB:_____
Last First MI

In signing below, I understand that:

1. _____**AUTHORIZATION TO TREAT**: I give Hands of Hope Clinic, its agents, and employee's authorization to treat the patient listed herein.
2. _____**PRIVACY PRACTICES**: I may review Hands of Hope Clinic's Notice of Privacy Practice at any time.
3. _____**INSURANCE COVERAGE**: I agree to notify Hands of Hope Clinic of any Medicaid, medical or dental insurance coverage and /or changes in coverage. Failure to do so will result in permanent dismissal from the clinic.
4. _____**FEES**: A flat-fee will be assessed for each visit. I understand that I will be determined eligible for services based on my annual household income and family size. In order to determine eligibility, I must provide verifiable and acceptable proof of income.
5. _____**PAYMENTS**: Fee for services are due on the day of service. If I fail to pay the visit fee at check-in, my appointment will be rescheduled. Additional fees for recommended treatments or labs will be discussed with me and I have the right to decline. If I desire labs or treatments associated with specialty care referrals that may incur expenses, I understand I will be responsible for these additional costs.
6. _____**PROOF OF HOUSEHOLD INCOME**: I must provide all documentation which applies for proof of household income such as all forms filed for most recent year's income tax return, (2) most recent pay stubs for everyone employed in the household, and/or recent government benefits letter showing current amount of benefits. My financial responsibility will be reassessed once (1) a year. If I fail to re-certify at the end of (1) year, all "clinic privileges" will TERMINATE.
7. _____**PROOF OF RESIDENCY**: I must provide all documentation which applies for proof of Henry County residency such as: (1) A valid Georgia Driver License, OR (2) A valid Georgia Identification Card, OR (3) A lease agreement or utility bill in your name AND valid Photo ID (Passport, Employer, Student).
8. _____**REHAB CENTERS AND SHELTERS**: If I currently reside at a center or shelter I must provide a letter or faxed referral at every appointment confirming my residency and employment status.
9. _____**APPOINTMENT CANCELLATION**: I understand that Hands of Hope Clinic requires a **24 Hour Advance Notice** of cancellation for any appointment. This also includes any outside referrals. **Two (2) no-shows in a twelve month period and I will be suspended from the clinic for one year.**
10. _____**LATE ARRIVAL**: Hands of Hope Clinic allows me a **15 minute grace period for late arrival** to my scheduled appointment. If I arrive more than fifteen minutes late, I will not be able to be seen. I understand this will be considered a **"no-show"**.
11. _____**MEDICATIONS**: All medication I receive through the dispensary and/or prescription assistance program (PAP) must be dispensed to me personally at time of pick up. By providing a written and signed consent, I can authorize another person to pick up my medication and he/she will be asked to provide valid photo ID. If I do not pick up medication within (3) months of being notified that the medications are ready

for pick up, then I will automatically donate them to Hands of Hope Clinic. Refusing to pick up medications on time can result in medication gaps and possible dismissal from the PAP offered at Hands of Hope Clinic. I understand that by receiving medications through the prescription assistance program (PAP) I must attend Loving Life Healthy Living classes provided at Hands of Hope Clinic. Sessions will be posted. I acknowledge that failure to attend the series will result in my dismissal from the PAP offered at Hands of Hope Clinic.

a. Hands of Hope Clinic does not stock, dispense, nor prescribe Narcotics and Anti-Anxiety Medications: (For example - Xanax, Ativan, Lortab, Hydrocodone, etc.).
b. Medication refills: I am required to call in my requests by leaving a voice mail with the NURSE LINE at least (2) TWO WEEKS before the refill is needed. PAP refills need to be called in to the PAP line at least (30) THIRTY DAYS before the refill is needed.

12. _____ **SELF-PAY & UNINSURED:** I understand that I will indicate "self-pay" and "uninsured" as it relates to payment status for all procedures & services that are associated with outside specialty care referrals. Hands of Hope Clinic **IS NOT** the responsible party for payment for expenses incurred regarding cost for procedures that are not covered under the hospital's financial assistance program.
13. _____**DISABILITY PAPERWORK**: I understand that Hands of Hope Clinic Volunteer Physicians are **NOT** able to complete or sign disability paperwork.
14. _____**TERMINATING SERVICES**: Hands of Hope Clinic strives to develop and maintain a cooperative and trusting provider-patient relationship with their patients. I understand that when such a relationship is not formed or is no longer proceeding in a mutually productive manner, services will be terminated. Circumstances that can result in service termination include but are not limited to the following:
    a. Noncompliance with treatments as recommended by the clinic, physicians, dentist, or other healthcare providers
    b. Threatening, swearing, or abusive behavior directed at support staff, volunteers, physicians, dentists, other healthcare providers or patients
    c. Being deceptive or lying
    d. Abusing medication
    e. Failure to comply with clinic policies
    f. Failure to inform clinic staff of changes to income and/or residency information in a timely manner

I have read, understand, and agree to these terms.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient (Or Guardian) | Printed Name of Person Signing | Date |


# Patient Consent for Use and Disclosure Of Protected Health Information

**Patient Name:** _____

I hereby give my consent for Hands of Hope Clinic (HOHC) to use and disclose health information about me to carry out Treatment and Health Care Operations. Hands of Hope Clinic "Notice of Privacy Practices" provides a more complete description of such uses and disclosures.

I have the right to review the "Notice of Privacy Practices" prior to signing this consent. Hands of Hope Clinic, reserves the right to revise its "Notice of Privacy Practices" at any time. A revised "Notice of Privacy Practices" may be obtained by forwarding a written request to: Hands of Hope Clinic, Privacy Officer at P. O. Box 1738, Stockbridge, GA 30281.

With this consent, Hands of Hope Clinic (HOHC) may call my home or other alternative location and leave a message on voice mail or in person in reference to any item that may assist the Clinic in carrying out Treatment and Health Care Operations, such as appointment reminders, and any calls pertaining to my clinical care, including test results.

With this consent, Hands of Hope Clinic (HOHC) may mail to my home or other alternative location any items that may assist the Clinic in carrying out treatment and health care operations, such as appointment reminder cards and patient statements, as long as they are marked "personal and confidential".

With this consent, Hands of Hope Clinic (HOHC) may e-mail mail to my home or other alternative location any items that may assist the Clinic in carrying out Treatment and Health Care Operations, such as appointment reminders and patient statements. I have the right to request that Hands of Hope Clinic restrict how it uses and discloses my PHI to carry out treatment and health care operations.

Hands of Hope Clinic (HOHC) is not required to agree to my restrictions request, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hands of Hope Clinic (HOHC) use and disclosure of my Protected Health Information and Treatment and Health Care Operations.

I may revoke my consent in writing except to the extent that the clinic has already made disclosures in reliance upon my prior consent. If I do sign this consent, or later revoke it, Hands of Hope Clinic (HOHC) may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Signature of Patient or Legal Guardian Date