PARTNERS for HEALING, INC.
PATIENT SCREENING FORM

Staff Use Only
Approved: Yes / No _____
DOH: Yes / No
Appt Date:_____
Appt Time:_____
Notified_____(Date/Initials)

☐ New Patient
Employed/dependent of someone Student Disability Transition/unemployed
☐ Returning Patient

Last Name_____First Name_____MI_____Date of Birth_____

Address_____City_____County_____ZIP _____

Social Security Number_____Phone #_____Cell #_____

Email Address_____Consent to Call: Y/N Consent to Text: Y/N

1. **Do you live in Coffee, Franklin or Moore County, TN?** YES / NO Coffee Franklin Moore Other
2. **Do you work in Coffee, Franklin or Moore County, TN?** YES / NO Coffee Franklin Moore Other
3. **Are you employed?** YES / NO **How many hours per week do you work?** _____
4. **Is someone in your home employed?** YES / NO **How many hours per week do they work?** _____
5. **Do you have any type medical insurance?** YES / NO
6. **What is the size of your household**;____(# Adults:_____#Under 18yrs:_____)

Patient Employer_____Phone #_____
Employer's Address_____

Spouse/Other Employer_____Phone #_____
Employer's Address_____

If you **do NOT work**, the following are exceptions that will allow you to become an established patient. Please check one of the boxes below and provide the required documentation within 10 days.

☐ **Proof of full-time student (12 or more credit hours).** This includes school schedule or award letter.

☐ **Receiving Disability income and insurance benefits have not started.** Must provide award letter with income stated on the letter.

☐ **In transition of work.** Patient must understand they have to gain employment within 6 months to meet eligibility requirements of the clinic. To acknowledge and accept the terms of this qualification sign below.

Signature of patient_____ Date _____

In the following table, please list the patient and any person in the household. Please bring in at least one document per person listed. Examples include two most recent check stubs, W2 or 1040 or bank statement (for direct deposit proof only).

Family Member Name	Relationship	Age	Source of Income	Hours worked per week	**Weekly Pay amount**	**Annual Pay amount**

I certify that the above information is true and accurate to the best of my knowledge and understand that I have 10 days to provide all documentation needed to qualify as an established patient. During this 10-day period or until you present the required documentation, you will be placed in a PENDING status for eligibility.

Signature of patient_____Date _____

*Required information before approval process may begin, all information subject to verification.

- ☐ TWO MOST RECENT PAYSTUBS, W2, 1040, OR BANK STATEMENT
- ☐ METERED MAIL, SUCH AS A UTILUTY BILL OR PHONE BILL
- ☐ INSURANCE VERIFIED
- ☐ COPY OF PICTURE IDENTIFICATION **Screeners Initials_____date received _____**

Scan under Admin/Eligibility Information
Revised 1/19