**Staff Use Only**

Approved: Yes / No

DOH: Yes / No

Appt Date: Appt Time: Notified (Date/Initials)

**PARTNERS for HEALING, INC.**

**109 W. Blackwell St. Tullahoma, TN**

**PATIENT SCREENING FORM**

 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 workedper week | **Weekly****Pay amount** | **Annual Pay amount** |
|  |  |  |  |  |  |  |
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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

 COPY OF PICTURE IDENTIFICATION

**Screeners Initials Insurance verification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date received**