



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: Choose an item. | Returning Patient

PERSONAL INFORMATION
LAST NAME, FIRST NAME, MIDDLE INITIAL
DATE OF BIRTH, SOCIAL SECURITY #, COUNTY
ADDRESS, CITY, ZIP
PHONE #, CELL #, CONSENT TO CALL
EMAIL ADDRESS, CONSENT TO EMAIL
WHAT IS THE SIZE OF YOUR HOUSEHOLD? # of Adults, # Under age 18
WHAT IS THE REASON FOR YOUR VISIT TODAY?
HOW DID YOU HEAR ABOUT PARTNERS?

EMPLOYMENT INFORMATION
1. IF EMPLOYED, WHAT COUNTY DO YOU WORK IN? Choose an item. How many hours per week do you work?
Employer Name, Phone Number, Address, City, Zip
2. IS SOMEONE IN YOUR HOUSEHOLD EMPLOYED? How many hours per week do they work?
Employer Name, Phone Number, Address, City, Zip
3. DO YOU HAVE ANY TYPE OF MEDICAL INSURANCE?
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 of the date you sign this form.
Proof of Full-time Student enrollment (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 Partners for Healing clinic. To acknowledge and accept the terms of this qualification, sign below.

**In the following table, please list the patient and any person(s) 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).

Table with 7 columns: 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 the 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 Documentation before approval process may begin, all information subject to verification.

- THREE MOST RECENT PAYSTUBS, W2, 1040, OR BANK STATEMENT
METERED MAIL, SUCH AS A UTILITY BILL OR PHONE BILL
INSURANCE VERIFIED
COPY OF PICTURE IDENTIFICATION

Screener's Initials: _____ Date Form Received: _____