**PARTNERS *for* HEALING, Inc.**

***PATIENT SCREENING FORM***

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| ***\*\*\* Staff Use Only \*\*\**** |
| *Approved:* | *YES / NO* |  |
| *DOH:*  | *YES / NO* |  |
| *Appt. Date:* |  |
| *Appt. Time:* |  |
| *Notified:*  |  *(Date/Initials)* |



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| --- | --- | --- |
|[ ]  New Patient: | Choose an item. |[ ]  Returning Patient |
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| **PERSONAL INFORMATION** | LAST NAME | Click here. | FIRST NAME | Click here. | MI Click here. |  |
| DATE OF BIRTH | Click here. | SOCIAL SECURITY # | Click here. | COUNTY | Choose an item. |
| ADDRESS | Click here. | CITY | Click here. | ZIP Click here. |  |
| PHONE # | Click here. | CELL # | Click here. |  CONSENT TO CALL |[ ]  Yes |[ ]  No |
| EMAIL ADDRESS | Click here. | CONSENT TO EMAIL |[ ]  Yes |[ ]  No |
| WHAT IS THE SIZE OF YOUR HOUSEHOLD?Click here. | # of Adults:Click here. |  | # Under age 18:Click here. |  |
| WHAT IS THE REASON FOR YOUR VISIT TODAY?Click enter. |  |  |  |  |
| HOW DID YOU HEAR ABOUT PARTNERS? Click here. |  |  |  |  |

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| **EMPLOYMENT INFORMATION** |  |
| 1. | IF EMPLOYED, WHAT COUNTY DO YOU WORK IN? | Choose an item. | How many hours per week do you work? | Click here. |
|  | Employer Name | Click here. | Phone Number | Click here. |
|  | Address | Click here. | City | Click here.. | Zip | Click here. |
| 2. | IS SOMEONE IN YOUR HOUSEHOLD EMPLOYED?Click or tap here to enter text. |  | HOW MANY HOURS PER WEEK DO THEY WORK? | Click here. |
|  | Employer Name | Click here. | Phone NumberClick here. |  |
|  | Address | Click here. | City | Click here. | Zip Click here. |  |
| 3. | DO YOU HAVE ANY TYPE OF MEDICAL INSURANCE? | Click here. |
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| 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. |

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| *\*\*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).* |
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| Family Member Name | Relationship | Age | Source of Income | Hours worked per 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 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 |[ ]  INSURANCE VERIFIED |
|[ ]  METERED MAIL, SUCH AS A UTILITY BILL OR PHONE BILL |[ ]  COPY OF PICTURE IDENTIFICATION |
|  |  |
|  | Screener’s Initials: |  | Date Form Received: |  |