HOPE CLINIC of GARLAND

Summary of Enrollments Documents-

1. Patient will need ID, DL, or Passports (Ok if expired due to Covid)

☐Financials-2021 tax returns or four of your most recent paycheck stubs.

2. If unemployed, we will need:

☐Unemployment award letter, Social Security award letter, and SNAP award letter. (Food Stamps)

3. If no income, we will need:

☐Statement of no Income and letter of support (we supply that for you)

4. Proof of address:
   ☐Utility bill-must be in your name 1. Gas, 2. Water or 3. Light, if living in an apartment then your current lease would suffice.

5. If living with someone and utility bills are not in your name-
   ☐You must provide the most current bill or lease agreement along with their identification.

   ☐Three mailings of anything with the patient's name that shows the patients name and address on it.

*** If you are a New Patient, applications are accepted on Wednesdays from 8-10am. ***

All applications MUST be completed prior to being processed

HOPE CLINIC of GARLAND

HOPE CLINIC

Delivering hope and health

800 S. 6th Street, Suite 100
Garland, TX 75040

Phone: 469-800-2500
hopeclinic-garland.org

Patient Information and History

Date: _____
Name: _____
Date of Birth _____ Sex: ◻ Male ◻ Female
SSN _____

Marital Status

◻ Married ◻ Separated ◻ Divorced ◻Single ◻Widowed

Address _____ Zip Code _____
Phone _____
Email Address _____

Race:

◻ American Indian/Aleutian (Indio americano/Aleusian) ◻ Hispanic
◻ African American ◻ Caucasian ◻Asian/Pacific (Asiantico/occidental)
◻ Unknown ◻ Other (otra)

Preferred Language

◻ English ◻ Spanish ◻ Other_____

Assistance

Are you currently receiving state medical assistance?
◻ Yes ◻ No
If yes, Which type?
◻ Medicaid ◻ Medicare ◻ Social Security Disability ◻ SSI ◻ Health Insurance Benefits
◻ Other_____

What best described your current employment status?

◻ Employer (Name, address, and Telephone number): _____
_____
◻ Unemployed ◻ Self-Employed ◻ Retired ◻Other
Have you ever applied for Parkland Health Plus
◻ Yes ◻ No

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Community Referral Form

Name: _____ Date: _____

Zip Code: _____ Phone: _____

We would like to know if there are any other difficulties, aside from your medical needs, that you or your family is currently experiencing. Our volunteer may go over this form with you to explore any appropriate referrals to the various social agencies in this community.

Would you like to talk with our volunteer about any of the following?

1. Anxiety/Depression/Stress	Yes_____	No_____
2. Clothing/Food Pantry/Food Stamps	Yes _____	No_____
3. Dental	Yes_____	No_____
4. Financial Asistance/Rent/Utilities	Yes_____	No_____
5. Housing	Yes_____	No_____
6. Immigration/Legal	Yes_____	No_____
7. Job Training/Education/GED	Yes_____	No_____
8. Mammogram/Pap smear	Yes_____	No_____
9. Nutrition/Exercise	Yes_____	No_____
10. Parenting	Yes_____	No_____
11. Recent death/Loss/Grief	Yes_____	No_____
12. Smoking/Drugs/Alcohol	Yes_____	No_____
13. Violence/Abuse	Yes_____	No_____
14. Vision	Yes_____	No_____

Please circle the answer that best describes your situation: Circle the correct answer

15. We worried whether our food would run out before we got money to buy more in the last 12 months

_____ Often true _____Sometimes true _____ Never True

16. The food that we bought just didn't last, and we didn't have money to get more in the last 12 months.

_____ Often true _____ Sometimes true _____ Never true

Notes: Any information you provide is strictly confidential and will only be shared with pertinent organizatons.

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FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA)

PATIENT NOTICE OF LIMITED LIABILITY

To be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

Notice to Patients:

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort claims Act (FTCA), (See 28 U.S.C 1346 (b), 2401 (b), 2671-80) provides the exclusive remedy for damage from personal injury, including: death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C 233 (a), (o)).

The above Federal law may cover certain free clinic health care professionals providing health care services to patients at this free clinic

CONSENT FOR CHARITY CARE

I,_____, acknowledge that the physicians of Hope Clinic of Garland, Inc. are volunteer health care providers and are not administering care for or in expectation of compensation. I also understand that as a volunteer health care provider, these physicians are immune from civil liability for any act or omission resulting in death, damage, or injury as long as the volunteer acts in good faith and in the scope of his or her duties within the organization in providing the health care services.

Furthermore, I realize that the civil liabilities of both the charitable organization and an employee of the charitable organization are limited to money. These limits apply to the employee and the organization separately; they are not aggregate limits

_____ _____

Patient's signature Printed Patient's Name

_____

Date

_____

Parent/Legal Guardian of Minor Signature

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PERMISSION FOR RELEASE OF INFORMATION

To: _____ Date: _____

Address: _____

_____

I hereby authorize and request you to release my medical records, financial records, psychological records, and/or other information concerning my illness and/or treatment to:

To: _____

(Doctor, hospital, individual, or agency receiving information)

Address: _____

_____

Documents Requested: _____

_____

I also authorize Hope Clinic of Garland, Inc. or its agents to release any and all information they feel is appropriate to other persons or agencies participating in planning or providing care for me. This consent will be considered valid while I am a patient at Hope clinic of Garland, Inc. unless I notify the clinic in writing that I withdraw my consent.

_____ _____

Patient Signature Date

_____

Patient Print name

_____

Patient Date of Birth

_____

Witness to patient signature

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NOTICE OF PRIVACY PRACTICE

I,_____, have read the copy of Hope Clinic of Garland, Inc.'s *Notice of Privacy Practices.*

_____

Print Patient's Name

_____ _____

Patient Signature Date

_____

Patient/Legal Guardian of Minor Signature

For Office Use Only

We attempted to obtain written acknowledgment of reading the copy of Hope Clinic of Garland Inc.'s Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (please specify)

_____

_____

_____

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Authorization for Release of Information

I hereby authorize Hope Clinic of Garland to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name: _____
Date of Birth: ___/_____/_____ Social Security Number _____ _____ _____
Patient Address: _____ Phone Number: _____
Date(s) of Service (if known): _____

Description of information to be released: (Check all that apply)

_____ Emergency room	_____ Admission/Registration Records	_____ Other
_____ Radiology Reports	_____ Consultation Reports	_____ Laboratory Report: _____
_____ History & Physical	_____ Physician's Orders	_____ Billing records: _____
_____ Nurse's Notes	_____ Operative Records	_____ Radiology Films
_____ Progress Notes	_____ Discharge Summary	

Description of the purpose of the use and/or disclosure: _____

The health information described herein shall be released to: (Check the appropriate category)

____ Hospital ____ Physician ____ Insurance Company ____ Attorney ____ Patient ____ Other

Name: _____
Address: _____
City, State, Zip: _____
Phone Number: (_____) _____ Fax Number: (_____) _____

(Check the appropriate delivery method)
____ Mail
____ Fax
____ Pick up Records
____ Other

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying Hope Clinic of Garland of this practice in writing at the address listed below. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation

Signature of Patient or Patient's Representative: _____ Date: _____
Printed Name of Patient's Representative: _____
Relationship to Patient: _____
Legal Authority (attach supporting documents): _____

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Patient Preference Regarding Communication of Health Information

I. Who to contact

I hereby give permission to the staff of Hope Clinic of Garland to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/or close personal friend(s):

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

_____ do not with to disclose any information with anyone.

II. How to Contact—I wish to be contacted in the following manner:

Home Telephone
____ OK to leave a message with detailed information
____Leave a message with call back number only

Work Telephone:
____Ok to leave a message with detailed information
____ Leave a message with callback number only

Cell Telephone
____ Ok to leave a message with detailed information
____ Leave a message with call back number only

Written Communication:
Ok to mail information to my home address: _____
_____
Ok to mail to my work/office address: _____
_____
Ok to fax to this number: _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require my specific authorization prior to the disclosure of medical information.

Patient Name or Legal Guardian: _____ Patient DOB: _____

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Patient Agreement and Permission to Treat

PATIENT'S NAME (PRINT): _____

Hope Clinic of Garland, Inc. is a non-governmental, non-profit agency. It is designed to provide health care to those families in Garland who have no other means of health care. To better serve you, we ask you for your cooperation in following the policies listed below. If you are unable to follow these guidelines, or find them unacceptable, another health care provider may be better able to meet your needs.

1. I understand that the examination and medical care given to me will be provided by a physician, physician's assistant or nurse practitioner
2. I am solely responsible for following through on testing and/or treatment prescribed by Hope Clinic providers.
3. I authorize any health care professional associated with Hope Clinic to disclose any personal, evaluation and/or treatment information to other health care professionals for continuation of care or for purposes of obtaining health care information from other facilities when medically necessary
4. I understand that I am solely responsible for the follow up on testing and treatment ordered by medical providers at Hope Clinic. I understand that if I fail to follow the medical providers' orders my treatment may be unsuccessful
5. I agree to inform Hope Clinic within 30 days of any changes in my name, address, telephone number, financial status, or if I have qualified for insurance of any kind
6. I agree to complete the required annual re-enrollment process and provide most current financial documents. If I fail to do so within 30 days, I understand that I will be dismissed from Hope Clinic and I will have to wait one year to re-apply.
7. I understand that if I miss three (3) consecutive appointments, I will be terminated from the clinic. If I call to cancel my appointment 24 hours in advance, this will not be held against me and I will allow the staff personnel to fill the appointment slot with another patient. I understand that I have to be on time for my appointment. A fifteen (15) minute grace period will be given to me. If I arrive after 15 minutes, I will be rescheduled
8. I understand that if I am uncooperative, verbally or physically abusive, intoxicated, or behave in an inappropriate manner I may not be eligible for services at Hope Clinic.

I have read, understand, and agree to the guidelines set by Hope Clinic of Garland, Inc. I understand that I can be denied further services provided by Hope Clinic of Garland, Inc. if I have given false or misleading information.

Patient Signature: _____ Date: _____

Print name of person signing (if different form patient): _____

Relation to patient: self-parent/guardian _____ other _____

Screener's signature: _____ Date: _____

(Copy to be given to patient. Original is kept in medical record)

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Income Verification Form

Is this your first visit to Hope Clinic in the past year? _____ Yes _____ No
Do you have any type of health insurance, Medicaid, or Medicare?
_____ Yes _____ No
Name: _____ Date:_____
Address: _____ City:_____State:_____ Zip code: _____
List all persons in household, including patient

NAME AND LAST NAME	RELATIONSHIP	AGE	OFFICE USE ONLY Documented Income	OFFICE USE ONLY Annual Income
1.	Patient			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
				TOTAL

To figure total projected annual Gross income-weekly x 52; bi-monthly x 26, monthly x 12

(If income varies please use average)

Family Status:
Female head of household_____ Disabled_____ Elderly_____ Child_____ (under 18 years old) _____
Race: (choose one)
□ White □ Black or Afro-American □ Asian □ American Indian of Alaska Native □ Hawaiian or other Pacific Island
□ Multi-Racial □ Other _____
Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino

Office Use Only
2016 Federal Poverty Level (200%)

Circle which income category the house size reflects: EXT. LOW VERY LOW LOW
Income Verification Date: _____ Intake Person: _____Council District: _____

_____

Warning: Title 18, Section 1001 of U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. Assistance provided using this application is through the United States Department of housing and Urban Development.

inancial Assistance Application

Acct #

HOPE CLINIC

Patient Information

Last Name	First Name	Middle Name	
DOB:	SSN	Telephone Number	
Address	City	State	Zip Code
Employer Name	Employer Phone #		
Employer Address	City	State	Zip code

Spouse or Legal Guardian Information

Spouse/Guardian Last Name	First name	Middle name	
Date of Birth	SSN	telephone Number	
Address (only if different from above	City	State	Zip Code
Employer name	Employer Telephone Number		
Employer Address	city	State	Zip code

Section A (Income) Please provide the income for each of the following persons in your household

		(This section is only used when the patient is a minor)	
Patient Income $	Frequency: [ ]Hour [ ]Week [ ]Month [ ]Year	Father Income $	Frequency [ ]Hour [ ]Week [ ]Month [ ]Year
Spouse income $	Frequency: [ ]Hour [ ]Week [ ]Month [ ]Year	Mother Income $	Frequency [ ]Hour [ ]Week [ ]Month [ ]Year
Total Income: $		Total Income:	

Section B (Family Members) Please provide the number of people in the patient's household: #

Section C (Income Verification) Please provide ONE of the following document types to verify income. These document types are listed in order of preference

1. Paycheck Remittance
2. IRS Form W-2
3. Tax Return
4. Employer Verification
5. Social Security, Worker's Compensation or Unemployment Compensation Determination letters
6. Proof of Participation in Government Assistance
7. Bank Statements
8. Other _____

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available _____

BaylorScott&White HEALTH

Baylor Scott & White Health
Financial Assistance Application

Patient Account Number

Patient Name (Last, First, MI) _____ Social Security Number _____

Patient's Residential Address _____ City _____ State _____ Zip Code _____ County _____

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

Birth Date (Month/Date/Year) _____ Telephone Number _____

Spouse's Name _____

Employed ☐ Yes ☐ No

Patient's Employer _____

Telephone # _____

Employed ☐ Yes ☐ No

Spouse's Employer _____

Telephone # _____

Are the BSWH facilities you received services at the closest in network facilities to your primary residence? ☐ Yes ☐ No

If no, were the closest facilities unable or unwilling to provide your care? ☐ Yes ☐ No

If unemployed, please include the previous employer's name and telephone number*

A. *Income:* Please provide the income for each of the following persons in your household.

Patient ☐ Full Time ☐ Part Time - Hours/Week = _____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$ _____ **Additional Income**

Spouse ☐ Full Time ☐ Part Time - Hours/Week = _____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$ _____ **Additional Income**

Total Household Income $ _____

Please complete only if patient is a minor (if not leave blank)

Patient's Father ☐ Full Time ☐ Part Time - Hours/Week = _____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$ _____ **Additional Income**

Patient's Mother ☐ Full Time ☐ Part Time - Hours/Week = _____
$ _____ ☐ Hr ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$ _____ **Additional Income**

Total Household Income $ _____

B. *Income Verification:* Please provide verification ***(send only copies, no original documentation)*** for all sources of household income (acceptable documentation listed below). Check attached documents:

☐ Paycheck Remittance ☐ Employer Verification ☐ Credit Inquiry (completed by BSWH)
☐ IRS Form W-2 ☐ Tax Return ☐ Governmental Assistance (food stamps, CDIC, Medicaid, TANF)
☐ Bank Statements ☐ Other (describe below) ☐ Social Security, Workers Compensation or Unemployment Compensation Determination Letters

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

_____

C. *Family Members:* **Please provide the total number of people in the patient's household.**
(This number should only include the patient, patient's spouse, and the patient's dependents) ☐

D. *Assets and Other Resources:*

Do you have any assets or other resources available to you? ☐ Yes ☐ No If Yes, current amount available: $_____
(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)

Do you have medical insurance? ☐ Yes ☐ No If Yes, please list provider name: _____

Do you have a Health Savings Account or Flexible Spending Account? ☐ Yes ☐ No If Yes, current amount available: $_____

I understand Baylor Scott & White Health ("BSWH") may verify the financial information contained in this Financial Assistance Application ("Application") in connection with BSWH's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize BSWH to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance.

I further understand that some physicians and providers may not be employees of BSWH. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

_____ _____ _____
Signature of Patient or Responsible Party **Printed Name** **Date**

For Hospital Use Only

☐ Application information obtained by BSWH Employee in person or over the phone, no patient signature required.

_____ _____
Electronic Signature of BSWH Employee or BSWH Representative Date

Notes Regarding Income Verification/Number in the Household: _____

☐ Patient is part of community care program **Program Name** _____ **First Statement Date:** _____

Hope Clinic of Garland, Inc.
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Jennifer Kampas, MD | Donna Bailey, MD | Allen Hefner, APP | Lynne Orozco, MD

PAST MEDICAL HISTORY: Please check any of the following medical conditions you have had in the past. Please note date of onset/diagnosis: (Ex. ☐ Diabetes – 1979)

- ☐ Abnormal Heart Rhythm
- ☐ Allergic Rhinitis
- ☐ Anemia/Blood Disorder
- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer, Type_____
- ☐ Chest Pain
- ☐ Colon Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Gastro-Esophageal Reflux Disease
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hepatitis/Liver Problems
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Migraine Headaches
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Stroke/TIA
- ☐ Substance Abuse/Alcoholism
- ☐ Thyroid Problem
- ☐ Tuberculosis

OTHER MEDICAL HISTORY List any other medical conditions you have been diagnosed with and the date of onset:

_____

_____

SURGICAL HISTORY List all surgeries with approximate date/year they occurred:

_____

_____

_____

_____

PATIENT NAME: _____ DOB: _____

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FAMILY HISTORY

RELATIONSHIP	LIVING?	PRESENT MEDICAL PROBLEMS / CAUSE OF DEATH
MOTHER/MATERNAL	☐ Yes ☐ No	_____
FATHER/PATERNAL	☐ Yes ☐ No	_____
Other		
_____		_____
_____		_____
_____		_____
_____		_____

Please check box for any of the following medical conditions in your extended family members and indicated relation in brackets ( ) Ex. ☐ Asthma (MATERNAL Aunt)

- ☐ Allergic Rhinitis
- ☐ Diabetes
- ☐ Migraine
- ☐ Anemia/Blood Disorder
- ☐ Emphysema/COPD
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Glaucoma
- ☐ Seizures
- ☐ Arthritis
- ☐ Heart Attack/Heart Disease
- ☐ Stroke/TIA
- ☐ Cancer, Type _____
- ☐ High Blood Pressure
- ☐ Substance Abuse
- ☐ Colon Problems
- ☐ High Cholesterol
- ☐ Thyroid Problem
- ☐ Depression/Anxiety
- ☐ Kidney Problems
- ☐ Tuberculosis Family Medical

PATIENT NAME: _____ DOB: _____

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Total Pregnancies: _____ Live Births:_____

Current Contraception Method: _____

SOCIAL HISTORY

OCCUPATION: _____

PREFERRED RELIGION:_____

RELATIONSHIP STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Common-Law Married ☐ Other

Do you think of yourself as:

☐ Gay, ☐ lesbian, or ☐ homosexual
☐ Straight or ☐ heterosexual
☐Bisexual

Do you identify yourself as a transsexual or transgendered?
☐ Yes ☐ no

TOBACCO USE: ☐ Never ☐ Currently ☐ In the past (amount/day _____ # years used_____)

MEDICATIONS: (List ALL medications, prescribed and over the counter, herbs and supplements):

_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS: (List allergies to medications ONLY and the type of reaction to each):

Pharmacy: Phone number and cross street of pharmacy where we will send your medications now or in the Future. Otherwise, you may have to return to pick up handwritten prescriptions if needed.

Pharmacy: _____

Address: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

PATIENT NAME: _____ DOB: _____

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PATIENT NAME: _____ DOB: _____

HEALTH MAINTENANCE / SCREENING:

Please list the approximate date for the following preventative services. Depending on your age/sex, not all categories may be applicable for you. On the services that list Normal/Abnormal or not sure, please circle one.

	Date of Last:		Date of Last:		Date of Last:
Tdap: (tetanus/whooping cough)		**Mammogram:** Normal/ Abnormal/Not Sure		**Colon Cancer Screening:** (Fit test, Cologuard, Colonoscopy)	
Pneumonia Vaccine(s): Prevnar/Pneumovax/ Not sure		**Pap Smear:** Normal/ Abnormal/ Not Sure		**Hepatitis C Blood Test:**	
Shingles Vaccine(s): Zostavax/Shingrix Not Sure		**Bone Density Test:** Normal/ Abnormal/ Not Sure		**Flu Vaccine:**	