Bridges to Health

NEW PATIENT INTAKE DOCUMENTATION NEEDED

Bridges to Health is a free health & dental clinic in Grant County for:

1) ***Grant County Residents***
2) ***without health insurance or access to medical care*** (NO Medicaid, NO HIP, NO Medicare, NO Veterans' medical benefits and NO private or employer-sponsored health insurance)
3) ***who make less than 300% of the poverty income guidelines***
   (for income guidelines see: http://bridges2health.org/Patient%20Guidelines.html)

Applications may be turned in *ONLY when accompanied by ALL REQUIRED PAPERWORK* (listed below) and at the following times: *Mon 10am to 2pm, Tues 1pm– 7pm, or Thurs 10am to 5pm*

Your application and supporting documents will be reviewed at the time you turn it in, and if all of your paperwork is complete you will be given an initial Intake Appointment (to determine eligibility). Once the Intake Appointment is completed you will be scheduled for an appointment with a medical provider.

LIST OF NEEDED PAPERWORK for APPLICATION:

Identification:

- **DRIVER'S LICENSE** (current Indiana driver's license or Indiana State Picture I.D.)
- **SOCIAL SECURITY CARD**

Grant County Residency:

- **MAIL/PROOF OF ADDRESS** (A current utility bill, mailed statement or other piece of legitimate mail showing your name and address and dated within the last 30 days. Must be typed and should have been delivered by the post office; PO Box addresses not accepted.)

Proof of Income:

(Income documents needed for spouse (if married) and all dependents over age 18 in household)

- **TAXES** (2015 Federal Income Tax 1040 Forms with attached schedules – **NOT W-2s**)
- **PAY STUBS** (Most current month's worth of pay stubs)
- **AWARD LETTERS** (All current year's Award Letters from Social Security, SSDI, SSI, Unemployment Compensation/Workman's Comp, Child Support, Pension/Retirement, TANF, etc.)

If you, your spouse or dependent adult children (over 18) are unemployed, self employed or drawing benefits (e.g. Social Security, retirement, etc.) you will need to also need to complete Work Force release:

- **WAGE VERIFICATION** complete top section of WorkForce release of information form
- **LETTER OF SUPPORT** from the person providing you with room and board or financial help (Sample "Letter of Support" provided in application packet or you may use your own)

Additional Documentation:

- *If you recently terminated or lost health insurance,* you need to provide a letter from the insurance company (or Medicaid) stating that you are no longer covered
- *If you are a Veteran,* you will need to bring a Denial Letter from the V.A. Eligibility Clerk, located at: U.S. Veterans Medical Center, 1700 E. 38th St., Marion

Bridges to Health Patient Application

(Only accepted with all required supporting documents)

PLEASE PRINT

Today's Date: _____

Name: _____ **Phone:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Social Security Number: _____ **Date of Birth:** _____

Employer:_____ **Alternate Phone:** _____

Dependent(s) Information (as would be listed on taxes):

Name:_____ Date of Birth: _____ Soc Sec #: _____

Name:_____ Date of Birth: _____ Soc Sec #: _____

Name:_____ Date of Birth: _____ Soc Sec #: _____

Name:_____ Date of Birth: _____ Soc Sec #: _____

(list additional dependents on the back of this sheet of paper)

Are you married? Yes No *(We need income verification for all dependents over the age of 18)*
Are you a veteran? Yes No *(If yes, we need a denial letter of benefits from the VA)*
Do you currently have *medical* insurance (including Medicaid/HIP/Medicare)? Yes No *(If yes, you do not qualify)*
Have you ever been a Bridges to Health patient in the past? Yes No ***If yes, when?*** _____

Previous Doctor(s) with address(es): _____

Major Health Issues/Health Concerns: _____

Please list ALL allergies: _____

MEDICATIONS (prescription & over-the-counter)	**STRENGTH**	***DOSE***

Please Note: ***Bridges to Health is a FREE Health Clinic; however, we do accept & welcome donations from patients. Please consider supporting the Bridges by making a small donation at each of your visits. Donations are optional, and are confidential, and donation boxes are located throughout the clinic for your convenience. Thank you for helping support Bridges to Health!***

BTH OFFICE USE ONLY: YES_____ NO_____ Date:_____ Reason: _____

Bridges to Health, 1251 West Kem Road, Marion, IN 46952
Phone # 765-662-7289, FAX #765-662-4708, www.bridges2health.org, info@bridges2health.org

CONSENT FOR RELEASE OF INFORMATION
MEDICAL RECORDS FORM

I hereby authorize Bridges to Health ("BTH"), to act as my designated representative in securing information from and providing information to: any County Department of Human Services, Social Security Administration, Internal Revenue Service, employers, hospitals, clinics, and/or physicians, and I hereby authorize said individual to release any and all medical records and information in connection with such efforts. I hereby release Bridges to Health from any liability arising from the release of the information in accordance with this consent.

I understand that once the above-referenced information is disclosed, it may be re-disclosed by the recipient and federal, state or local privacy laws or regulations may not protect the information in any way.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I may also request a copy of this consent after I sign it.

I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing to Bridges to Health. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked in writing, this consent form will be valid for a period of one year from date of signature.

Patient Name:_____

Address: _____

City: _____ State:_____ Zip: _____

Phone Number:_____DOB: _____ SSN: _____

Signature:_____ Date:_____

Witness Signature: _____ Date:_____

This authorization will expire one year from the date of signature.

PATIENTS PLEASE COMPLETE INFO BELOW FOR EACH DOCTOR/CLINIC/HOSPITAL BRIDGES NEEDS TO GET YOUR MEDICAL RECORDS FROM:

From: _____ *(Doctor/Clinic/Hospital)*

*Address:*_____ *Fax #:* _____

City: _____ *State:* _____*Zip:*_____

The patient's entire medical records for the past five years are to be disclosed to Bridges to Health for the following purpose: Transfer of care

Bridges to Health

Support Letter:

This Support Letter is to be completed if an individual is not currently working and has no other source of income. If a patient is working they DO NOT need to complete this letter.

The Support Letter shows Bridges how the patient/person applying to be a patient is living day-to-day without an income. This letter does NOT indicate that any actual money has changed hands, but is rather an estimate of financial value of help that is being given.

I, _____ provide room and board to _____
(Printed name of person providing support) (Name of Bridges Patient)

valued at $_____ per month.
(estimate of value of help)

Signature of Person Providing Support: _____

Date: _____

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