



Welcome to Hands of Hope Clinic!

Thank you for your interest in becoming a patient at Hands of Hope Clinic. We are honored that you have chosen us as your partner in health.

Hands of Hope Clinic is a nonprofit, charitable care clinic committed to providing compassionate, high-quality **medical, dental, and mental health care** to uninsured Henry County residents. Our mission is to bring hope and better health to our community, and we are here to support you on your journey to wellness.

Eligibility Requirements

To qualify for services at Hands of Hope Clinic, you must meet the following criteria:

1. Be a resident of **Henry County**
2. Be **uninsured** (not covered by any form of health insurance, including Medicaid, Medicare, or VA Benefits)
3. Meet **income guidelines** based on the federal poverty level

Next Steps

Please complete and return the attached forms, along with all requested documentation, so we can begin your eligibility screening. Once certified, you will be scheduled for the next available appointment.

Eligibility certifications can be done either as a **walk-in** or by **appointment**:

- **Walk-in hours:** Tuesday–Thursday, 9:30–11:30 AM or 2:00–4:00 PM
(Please note: Walk-ins may experience a wait depending on staff availability.)
- **Appointments (*preferred*):** To avoid wait times, you may call the clinic at 770-507-1344 to schedule a certification appointment.

We're Glad You're Here

At Hands of Hope Clinic, you are more than a patient—you are part of a caring community. We are committed to treating every individual with dignity, compassion, and respect, and we look forward to supporting your health and well-being.



Eligibility Screening

Welcome & Why We Ask for This Information

Hands of Hope Clinic provides medical, dental, and mental health services to uninsured and low-income residents of Henry County. To make sure we are serving those who qualify and to meet audit requirements, we ask that every patient complete this form honestly and fully. All information is kept confidential and used only to determine eligibility for services.

Who We Are Able to Serve (Eligibility Checklist)

1. Applicant must be a Henry County resident, aged 18 – 64 years.
2. Must be uninsured; Cannot have private insurance or be eligible for Medicaid, Medicare, VA Benefits
3. Have a low to moderate annual income; determined by federal poverty guidelines

Please answer the following questions.

1. RESIDENCY REQUIREMENT

Are you a current Henry County resident? Yes No

Please provide us with at least one of the following documents:

Henry County ID Current Utility Bill Lease Other _____

2. INSURANCE INFORMATION

Do you have insurance that covers? (check all that apply)

Health Dental Vision No Insurance

Do you currently have Georgia Medicaid? Yes No Medicare Part B? Yes No

Do you currently have Social Security Disability Insurance? Yes No

Have you applied for Medicaid? Yes No

3. FINANCIAL ELIGIBILITY

Tell Us About Your Household

How many people are in your household (including yourself & spouse): _____

How many dependents do you have (if any): _____

If you have dependents, what are their ages: _____

Are you employed? Yes No

Is your spouse/partner employed? Yes No N/A

Your Family's Financial Information

Please list all income sources for anyone in your household.

Source of Income	Monthly Amount (Myself)	Monthly Amount (Spouse/Partner)	Notes
Wages or salary (job, tips, bonuses)	\$ _____	\$ _____	_____
Self-employment income	\$ _____	\$ _____	_____
Unemployment, disability, food stamps	\$ _____	\$ _____	_____
Child support or alimony	\$ _____	\$ _____	_____
Retirement, Social Security, or pension	\$ _____	\$ _____	_____
Rental or business income	\$ _____	\$ _____	_____
Other income (please explain)	\$ _____	\$ _____	_____

Total Estimated Gross Monthly Household Income: \$ _____

➤ If You Currently Do Not Have Income

I/We currently have **no income** of any kind.

Do you receive help from:

Family or friends Church/community group Government assistance

Other: _____

Note: You may be required to fill out a Zero Income Affidavit which must be notarized.

Please fill out your approximate monthly living expenses (best estimate) and who offers you assistance with these expenses.

Expense Type	Amount	Help Received From	Notes
Housing (rent/mortgage)	\$ _____	_____	_____
Utilities (electric, water, gas)	\$ _____	_____	_____
Food & groceries	\$ _____	_____	_____
Transportation (gas, insurance, bus)	\$ _____	_____	_____
Phone & internet	\$ _____	_____	_____
Medical expenses	\$ _____	_____	_____
Other (childcare, personal items, etc.)	\$ _____	_____	_____

Prescription Assistance Programs

NOTICE: If you would like to participate in our free or low-cost prescription assistance programs you will need to provide us with the following documents:

- Medicaid Denial Letter
- Most Recent Tax Return
- Other documents requested by staff

These documents are required by the pharmaceutical companies.

Your Promise of Honesty (Certification)

I understand that this information is used to determine eligibility for Hands of Hope Clinic services. I certify that the information provided is true and complete to the best of my knowledge. I understand that giving false or incomplete information may affect my eligibility for services.

Patient Name: _____

Patient Signature: _____

Date: _____

Staff Use Only

Reviewed by: _____ Date: _____

Notes:

NAME _____

DATE OF BIRTH _____

MEDICATIONS

Medication Name (include all prescriptions, vitamins & over the counter)	Dose	Frequency	For what?

ALLERGIES/CONTRAINDICATIONS No known allergies

Name	Reaction

MEDICAL HISTORY

Allergies	YES	NO	Depression	YES	NO	Myocardial Infarction	YES	NO
Anemia	YES	NO	Diabetes Mellitus	YES	NO	Nerve/Muscle Disease	YES	NO
Anxiety	YES	NO	Dexa/Bone Density	YES	NO	Osteoporosis	YES	NO
Arthritis	YES	NO	Emphysema	YES	NO	Seizures	YES	NO
Asthma	YES	NO	GERD	YES	NO	Shortness of Breath	YES	NO
Blood Transfusion	YES	NO	Glaucoma	YES	NO	Sickle Cell Anemia	YES	NO
Cancer	YES	NO	Heart Murmur	YES	NO	Stroke	YES	NO
Cataracts	YES	NO	High Cholesterol	YES	NO	Substance Abuse	YES	NO
Chest Pain	YES	NO	HIV/ AIDS	YES	NO	Thyroid Disease	YES	NO
CHF	YES	NO	Hypertension	YES	NO	Tuberculosis	YES	NO
Clotting Disorder	YES	NO	Kidney Disease	YES	NO	Ulcers	YES	NO
COPD	YES	NO	Meningitis	YES	NO	Migraines	YES	NO
Fatigue	YES	NO	Sleep Apnea	YES	NO			

Other Medical History: _____

SURGICAL HISTORY

AAA Repair	YES	NO	Colon Surgery	YES	NO	Joint Replacement	YES	NO
Appendectomy	YES	NO	Cosmetic Surgery	YES	NO	Intestine Surgery	YES	NO
Brain Surgery	YES	NO	Eye Surgery	YES	NO	Spine Surgery	YES	NO
CABG	YES	NO	Fracture Surgery	YES	NO	Tonsillectomy	YES	NO
Cholecystectomy	YES	NO	Hernia Repair	YES	NO	Tubal ligation	YES	NO
Colon/ Bowel Surgery	YES	NO	Hysterectomy	YES	NO	Valve Replacement	YES	NO
			Vasectomy	YES	NO	Prostate Surgery	YES	NO

Other Surgical History: _____

FAMILY HISTORY

Relationship	Alive?	Alcohol Abuse	Arthritis	Asthma	Autoimmune disorder	Cancer	COPD	Depression	Diabetes	Drug Abuse	Heart Disease	Hyperlipidemia	Hypertension	Kidney Disease	Learning Disability	Mental Illness	Stroke	Vision Loss	Other/Comments	
Mother	Y N																			
Father	Y N																			
Sister 1	Y N																			
Sister 2	Y N																			
Sister 3	Y N																			
Brother 1	Y N																			
Brother 2	Y N																			
Brother 3	Y N																			
Son 1	Y N																			
Son 2	Y N																			
Daughter 1	Y N																			
Daughter 2	Y N																			
Mat GM	Y N																			
Mat GF	Y N																			
Pat GM	Y N																			
Pat GF	Y N																			
	Y N																			
	Y N																			
	Y N																			

Adopted

Family History Unknown

Other Family History: _____

ALCOHOL SCREEN

Have you ever had more than 4 drinks in a day? Yes No

How many times in the past 12 months? 0 1 2 3 4 5 +

SOCIAL HISTORY

Alcohol Use? Yes No

Drinks/Week Glasses of wine
 Cans of beer
 Shots of liquor
 Drinks containing 0.5oz of alcohol

Sexually Active? Yes No Not Currently

Partners Female Male

Birth Control/Protection:

- None
- Abstinence
- Coitus Interruptus
- Condom
- Diaphragm
- Implant
- Injection
- Inserts
- IUD
- OCP
- Patch
- Post-menopausal
- Rhythm
- Spermicide
- Sponge
- Surgical
- Other-see comments

NAME _____

DATE OF BIRTH _____

Drug Use? Yes No

Use/week _____ times a week

Type

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Amyl Nitrate | <input type="checkbox"/> Anabolic Steroids | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> "Crack" cocaine | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Fentanyl | <input type="checkbox"/> Other | <input type="checkbox"/> GHB | <input type="checkbox"/> Hashish |
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Hydrocodone | <input type="checkbox"/> Hydromorphone | <input type="checkbox"/> Ketamine |
| <input type="checkbox"/> LSD | <input type="checkbox"/> Marijuana | <input type="checkbox"/> MDMA (Ecstasy) | <input type="checkbox"/> Mescaline |
| <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Methaqualone | <input type="checkbox"/> Methylphenidate | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Opium | <input type="checkbox"/> Oxycodone | <input type="checkbox"/> PCP |
| <input type="checkbox"/> Psilocybin | <input type="checkbox"/> Solvent Inhalants | <input type="checkbox"/> Other- see comments | |

Comments: _____

Tobacco Use? Yes NoIf so, Ready to Quit? Yes No Smoker, Currently # Packs/day: _____ Former Smoker, Previously Quit Date: _____ # Packs/day: _____ Smokeless Tobacco, Currently Smokeless Tobacco, Previously Quit Date: _____ # Packs/day: _____

Comments: _____

SOCIOECONOMIC HISTORYOccupation: _____ Retired

Employer: _____

Spouse Name _____

of Children _____

Language English Spanish Chinese French Vietnamese Arabic German Greek Italian Hindi
 Russian Sign Language Thai Somali Other: _____Ethnicity Hispanic or Latino Non-Hispanic or LatinoRace Black/African American White/Caucasian Asian American Indian Hawaiian/Pacific Islander
 Other Refuse to answer

Lives with: _____

HEALTH MAINTENANCE

Please document the date of last completion and results if appropriate for the following:

Screening	Date Completed	Result/Comments
Pap smear / pelvic (women only)		Normal or Abnormal? <input type="checkbox"/>
Mammogram		Normal or Abnormal? <input type="checkbox"/>
Colonoscopy		Normal or Abnormal? <input type="checkbox"/>
DEXA./Bone Density Scan		Normal or Abnormal? <input type="checkbox"/>
PSA (men only)		Normal or Abnormal? <input type="checkbox"/>

NAME _____

DATE OF BIRTH _____

VACCINATIONS

	Have you received this vaccine?	Year(s) given
Influenza vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Hepatitis vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Pneumonia Vaccine (Pneumovax or Prevnar13)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Tetanus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Tdap	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Zoster/shingles vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
HPV vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
BCG (outside U.S.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	

OTHER PHYSICIANS

As your Primary Care Provider, it is our job to make sure we keep current with your other physicians and careteams. Please list your providers names below.

Heart specialist:	OB/GYN:
Digestive specialist:	Neurologist:
Endocrinologist:	Eye Doctor:
Orthopedist:	Pain Management:
Urologist:	Physical/Occ therapist:
Kidney specialist:	Dermatologist:
Counselor:	Cancer specialist:
Other:	

Are you interested in signing up for our Patient Portal, MyChart? Yes No



Patient
Initials

Primary Care Provider

I understand that Hands of Hope Clinic is my Primary Care Provider (PCP). This is where I go when I get sick or have other health needs. The ER should be used for emergencies only.

When I get sick or have a concern

I can call the clinic, leave a detailed message, and a staff member will call me back within one business day. I understand multiple messages are not necessary and can delay response time.

What will I have to pay?

Hands of Hope Clinic provides services at a reduced cost and requires a minimal, flat-rate copay from all patients.

- A new patient visit with a provider is \$20. This visit would normally cost you over \$200, but we find donors who help cover the additional costs for you.
- An established patient visit is just \$10, instead of over \$100; Specialty visits are only \$20. Specialty physicians (cardiologists, urologists, ENTs, etc.) would normally cost several hundred dollars per visit.
- Dental consultations are no-charge; Dental procedures & cleanings are just \$10 per visit.
- Mental Health Counseling is no-charge, due to generous grantors.
- Lab work and imaging services ordered by Hands of Hope Clinic are provided by Piedmont Henry Hospital at no cost to you. HOHC does not cover the cost of ER visits or other hospital procedures.

No-Show and Late Cancellation Fees

Hands of Hope Clinic has limited resources, and every missed appointment is a lost opportunity to care for another patient in need. For this reason, we strictly enforce the following policy:

- No-shows will result in a \$20 fee; Late Cancellations (less than 48 hours' notice) will result in a \$10 fee. All fees must be paid before you can be rescheduled.
- Two or more no-shows or late cancellations within 12 months may result in dismissal from the clinic for up to one year. Your cooperation helps us serve more people in our community. **See full list of Co-Pays & Fees.**

Change in Insurance or Residency Status

You are required to notify us if at any time you gain insurance coverage or move out of Henry County. Failure to do so can lead to dismissal from the clinic. Being deliberately untruthful or falsifying information will result in a permanent dismissal.

Medication Assistance

Hands of Hope Clinic works diligently to help patients obtain the medications they need for free or low cost. Programs include Prescription Assistance Programs—we apply for free medications on your behalf directly from the drug makers; GoodPill Pharmacy—a low-cost pharmacy that ships medicine to your home; Medication samples, as available.

HOHC does not pay for medication

If we are unable to get your medicine through our assistance programs, we will send the prescription to a local pharmacy of your choice. You will have to pay the pharmacy when you pick up your medication. We try very hard to find the lowest cost drugs that will treat your condition and help you find coupons when possible.

Medication Refills

When you need a refill call the clinic and leave a message on the refill line. Messages are checked several times daily during regular business hours. We require at least 7 days to process refill requests. It is your responsibility to request refills BEFORE you have run out.

Follow your provider's plan for you

Patients at HOHC are expected to follow the treatment plan provided by their healthcare provider. This includes taking all medications as prescribed, completing recommended tests or referrals, and following through with medical instructions. *Do not stop, change, or adjust your medications or treatment plan without first consulting your provider.* Doing so may put your health at risk. Consistent non-compliance with medical advice—such as repeatedly missing follow-up care, refusing treatment, or not taking prescribed medications—may result in dismissal from the clinic. Your active participation in your care is essential to your health and success in treatment.

Recertify each year

To continue to receive medical, dental, and/or mental health care at HOHC, you must recertify each year. Failure to do so will keep you from being seen at the clinic and getting refills of your medication. We will remind you when it is time to recertify.

Treat everyone with respect

Kind words work better. Hands of Hope Clinic is a place of respect and care. Disrespectful, threatening, or inappropriate behavior toward staff, volunteers, or other patients will not be tolerated. **Clinic staff reserve the right to dismiss any patient** at their sole discretion for rude, unsafe, or disruptive conduct.

Patient Acknowledgement

I know that Hands of Hope Clinic is a nonprofit charitable organization and that some of my care may be given by volunteer healthcare providers. I'm thankful for their help and understand that I will not hold the clinic or its volunteers responsible for the results of my care, except as required by law.

Patient Name: _____ Patient Signature: _____ Date: _____

Reviewed with patient by: _____

(Staff Member)

We appreciate your compliance and look forward to having you as a patient!



AFFIDAVIT

PATIENT NAME: _____ DOB: _____

Patient Acknowledgment and Certification

By signing below, I certify that the information I have provided on this form—and any accompanying documents submitted for eligibility at Hands of Hope Clinic—is true and complete to the best of my knowledge.

I understand that providing false or misleading information may constitute a felony under Georgia law and is punishable by either a fine of not more than \$1,000.00 and/or possible imprisonment. **I further understand that any falsification of information will result in immediate dismissal from the clinic and disqualification from receiving services.**

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative

PATIENT CONTACT INFORMATION

Address:

City: _____ County: _____ Zip _____

Home Phone: _____

Cell: _____