Eligibility Screening

Patient Eligibility Requirements:

1. Applicant must be a Henry County resident, aged 18 – 64 years.
2. Household income must be at or below 300% of the federal poverty level*.
3. Cannot have insurance or be eligible for Medicare, Medicaid, or VA Benefits.

Please answer the following questions.

1. RESIDENCY REQUIRMENT:

Are you a current Henry County resident? □ Yes □ No

- Documents needed (at least one):
  □ Henry County Driver's License □ Utility Bill □ Lease

2. FINANCIAL ELIGIBILITY

Your income must be at or below 300% of the Federal Poverty Level to be eligible to receive services at Hands of Hope Clinic. **See chart below***

Please provide the number of dependents in your household (include self/spouse) _____.

Please provide gross family **monthly income** from all sources **$**_____.
(Include Wages, Food Stamps, Child Support, Unemployment, Disability, Retirement, etc.)

*** 2025 Federal Poverty Guidelines**

Household/ Family Size	100% FPL (monthly income)	200% FPL (monthly income)	300% FPL (monthly income)	$300% FPL (annual income)
1	$1,304.17	$2,608.33	**$3,912.50**	$46,950
2	$1,762.50	$3,525.00	**$5,287.50**	$63,450
3	$2,220.83	$4,441.67	**$6,662.50**	$79,950
4	$2,679.17	$5,358.33	**$8,037.50**	$96,450
5	$3,137.50	$6,275.00	**$9,412.50**	$112,950
6	$3,595.83	$7,191.67	**$10,787.50**	$129,450

3. 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

Recommended Documents: Needed for Prescription Assistance Programs
If you are interested in participating in our free & low-cost prescription programs, you must provide us with following documents: □ Medicaid Denial □ Most Recent Tax Return

HANDS of HOPE CLINIC

Patient Information- Please complete all sections and print clearly

Name:_____
First **Middle** **Last**

Gender: □ **Male** □ **Female** **Date of Birth**:_____/_____/_____ **Social Security #**_____-_____-_____

Street Address: _____

City_____ **State** _____ **Zip Code**_____ **County of residence:** _____

E-Mail Address:_____

Mobile Phone (primary) (_____)-_____-_____ **Other phone** (_____)-_____-_____

I agree to receive automated calls & texts for appointment reminders & other clinic updates □ **Yes** □ **No**

Race: □ **White** □ **Black** □ **Asian/Pacific Islander** □ **Black/African American** □ **Other**_____

Ethnicity: □ **Hispanic** □ **Non-Hispanic**

Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Separated** □ **Widowed** □ **Partner**

Number of children under 18: _____ **Income:**_____

Employer:_____ **Occupation:**_____

How did you hear about us? □ **Piedmont Henry Hospital** □ **Other Hospital** □ **Other Physician Office**

□ **Word of Mouth** □ **Current/Previous Patient** □ **Ads/Social Media** □ **Family/Friends** □ **Other**

***If Other, please specify:** _____

Emergency Contact: _____

Relationship_____ **Mobile Number** (_____)-_____-_____

Please list all medications you currently take: _____

_____

HANDS of HOPE CLINIC

PATIENT RESPONSIBILITIES & FREQUENTLY ASKED QUESTIONS

Staff Initials | 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.

Staff Initials | Patient Initials

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.

Bring your medicine bottles to each appointment

It is important to your provider to review all your medications at each appointment. It's easy to forget what you are taking or the amount. That is why we ask that you bring all your medication bottles to each appointment.

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: _____

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:**

_____