# Friends In Need

1916 Brookside Drive Kingsport, TN. 37660 (423) 246-0010

Thank you for expressing an interest in becoming a patient of Friends In Need Health Center. Friends In Need is a faith based organization providing medical and dental care for qualified residents. We are able to provide services thanks to the generous contributions from donors and volunteers. We also rely on fees for services charged to our patients on a sliding scale that is based on income and number of dependents.

## How To Apply:

Please complete all sections, on all pages of the application-
BRING in Completed Application along with documentation (items needed are listed below) between the hours of 9 a.m. - 4 p.m. Monday through Thursday.
New patient enrollment is managed on a first come, first serve basis.
If the application is not completely filled out and acceptable eligibility documentation is not provided, you will be asked to return on another day with complete application and any missing documents.

## Acceptable Documentation:

Uninsured Individuals/FamiIies with no medical/dental will need to provide documents below in order to assist us in determining the percentage you will pay for services at Friends In Need Health Center.

- Proof of Residency (ex- Utility Bill, Telephone Bill, or Cable Bill- something thal can verify your address)
- A copy of recent pay stubs for the past 30 days for all income earners in your household. The statement should show year-to-date income, and taxes withheld. If you are self employed you must bring your bank statement showing deposits from income earned.
- A copy of previous years filed income tax returns, signed and dated (with Schedule C, if self employed)
- A copy of any letters you may have regarding Food Stamps, SNAP, TANF, or any other public assistance.
- A copy of all documents verifying Disability Income, Social Security Income, Pension Payments, Child Support, or any other income for members of your household/family. .
- Photo Identification (Drivers License), and Social Security Cards for all applicants
- Individuals receiving only Disability or Social Security Income may submit the documentation listed above to be considered for Dental Only Services at Friends In Need.

We at Friends In Need look forward to serving your health care needs. Please call us, if you have any questions.

Sincerely,

Friends In Need Health Center, Inc.

# FRIENDS In Need Health Center, Inc.

# Application for Friends In Need Health Center, Inc.

ÜNew Application [3 Update ofExisting Patient

Have you everbeen seen at Friends In Need? [3 Yes No

Are you a patient of Healing Hands,, Crossroads Medical Mission, Providence Clinic, Health Department? C] Yes No

---

Full Name Sex

Date of Birth Age Social Security Number

Address City State Zip Code Email County in which you live

Ilome, Telephone Number Cell Telephone Number

Are you etnploycd'? C] No, please indicate why'? (hotnernaker, disabled, unemployed, retired)

Yes : Applicants Employer

Employer Address

Employer Telephone Number How long have you worked 'there'?

Marital Status: Married Single Divorced Separated Widowed

Race: White ÜAsian ÜBIack/AfricanAmerican ÜAmerican Indian/Alaska Native

ONative Hawaiian ÜOtherPacificIslander Refused to report

Ethnicity: [3 Hispanic/Latino Not Hispanic/Latino Unreported/refused to report

Do you have the following health insurance and/or access to the following health insurance?

TennCare/Medicaid: Dyes ONO Veteran's Benefits:ÜYes ONO

Medicare Part A: C]Yes ONO Medicare Part B: D Yes ONO Medical

I_nsurance: OYes ONO Dental Insurance: Dyes O$^{N}$O

Are you applying for our medical services? Dyes No

Are you applying for our dental services? YesÜ No

Do Not Write Below This Line - For StaffO,,1y -

---

| Number of People in Household | Percentage | Approval | Dale |
|---|---|---|---|
| | | | |

| | | | |
|---|---|---|---|
| | Medical %_____<br>Dental % _____ | | |

# FRIENDS Application for Friends In Need Health Center, Inc.

In Need
Health Center, Inc.

ÜNew Application  Update of Existing Patient

Have you ever been seen at Friends In Need?  Yes  No

Are you a patient of Healing Hands, Crossroads Medical Mission, Providence Clinic, Health Department? Yes No

Second Applicant:

Full Name  Relationship to Applicant:

Date of Birth  Age _  Sex  Social Security Number

Address  City

State  Zip Code  Email  County in which you live

Home Telephone Number  Cell Telephone Number

Are you employe(l'?  No, please indicate why? (homemaker, disabled, unemployed, retired)

Yes : Applicants Employer

Employer Address

Employer Telephone Number  How long have you worked there'?

Marital Status: [3 Married  Single  Divorced [3 Separated  Widowed

Race:  White DAsian OBIack/African American DAmerican Indian/Alaska Native

DNative Hawaiian 00ther Pacific Islander  Refused to report

Ethnicity:  I-lispanic/Latino  Not Hispanic/Latino  C] Unreported/refüsed to report.

Do you have the following health insurance and/or access to the following health insurance?
TennCare/Medicaid: O Yes ONO Veteran's Benefits:ÜYes ONO
Medicare Part A: ☐Yes ☐No Medicare Part B:Yes

Medical Insurance: ONO Dental Insurance: ONO

Are you applying for our medical services? C] NO

Are you applying Iör our dental services? YesÜ NO

***Do***Not Write Below T'his Line — For Stuff Only_

---

| Number of People in Household | Percentage | Approval | Date |
|---|---|---|---|
| | Medical % _____<br>Dental % _____ | | |

Sources of Income:

| Income | Applicant (Gross $ pcr Month) | 2[1rd] Applicant ($/month) | ()thcr [)cpcndents ($/month) |
|---|---|---|---|
| Employment $ | | | |
| Social Security $ | | | |
| I)isabilit.y $ | | | |
| (Jncmploymc.nt $ | | | |
| Child Support $ | | | |
| Public Assistance | | | |
| ()ther Income $ | | | |
| 'Total Income $ | | | |

I cer1ilY that the införnuation given is true. and co:nplete- I undel*land that it'l give False inlunnalion or withhold införn•ation,

I will no longer be eligible _lör Friends In Need Services

Applicant Signature: Date:

_____ _____

Second Applicant Signature Date:

_____ _____

Do Not rite Below This Line
This section to be completed by Friends In Need Staff

---

| Income | Applicant | Source | Second Applicant | Source |
|---|---|---|---|---|
| Employment $ | | | | |
| Social Security $ | | | | |
| Disability $ | | | | |
| Unemployment $ | | | | |
| Child Support $ | | | | |
| Public Assistance $ | | | | |
| Other Income | | | | |
| Total Income $ | | | | |

| Number of People in Household | Percentage | Approval | Date |
|---|---|---|---|
| | Medical % _____<br>Dental % _____ | | |

F-137
Rev- 5/2011