HEALTHCARE APPLICATION - WELLNESS TREE COMMUNITY CLINIC

Name: ____ **Date:** __________________

Date of Birth: ____________ **SS#:**_______________ **Email:** _____________________

Home Phone: _______________ **Cell:** _______________**Work:** ___________________

Address: _____________________ **City:** _______________ **St.** ______ **Zip:** ________

If a minor, Parent's Name:____

Do you have Medicaid, Medicare or other Health Insurance? Please Circle ➡ Yes or No

NOTES:

1. If you have a health insurance policy that has a $1,000 deductible, or greater, and you cannot afford to see a doctor because of your deductible and low income, we still might be able to serve you. Subject to individual review & approval, we can see patients in this situation until their deductibles have been met. Once the deductible has been met you will no longer be eligible for our free services for the remainder of the year.

2. **I attest that my household income is at, or below:** (At home dependents under 18 yrs.)

# of Family Members	Annual Income	=	Monthly Income
1	**$23,340**	**=**	**$1,945**
2	**$31,460**	**=**	**$2,621**
3	**$39,580**	**=**	**$3,298**
4	**$47,700**	**=**	**$3,975**

For each additional family member over 4 persons: Add $8,120 to annual figure.

3. I certify that I am employed, actively seeking employment, or briefly describe situation which prevents employment:____

____

4. I understand that I must be responsible for all written prescriptions.
5. I understand that I must be responsible for hospital performed procedures, unless the charges are waived by them in advance. (Waivers or Vouchers need to be in writing.)
6. I understand that I must be responsible for services performed by medical specialists to whom I have been referred to by any Wellness Tree Community Clinic provider, unless the charges have been waived by the provider in advance. (In writing)
7. I understand that the Wellness Tree Community Clinic does not do examinations or paperwork for Disability Determinations, Social Security, or Workman's Comp..

_______________________________ _______________________________

APPLICANT WITNESS

*** IMPORTANT NOTICE ***

NO SHOWS: When you fail to keep your appointment you have deprived another person an opportunity to have a Provider visit. Therefore, we require at least a 24-hour notification if you cannot keep your appointment. If you lose track of when your appointment is please call us! One (1) No-Show without prior notification will prompt us to place your name on our no-show patient list! Two (2) No-Shows without sufficient notification will eliminate you from being able to schedule future day-time appointments. (You may come to evening walk-in clinics.)

Volunteer Health Care Provider Immunity

(Please read carefully)

TITLE 39 – 7703 of Idaho Statues provides immunity from liability for Health Care Providers Providing Charitable Medical Care.

(1). Any healthcare provider who voluntarily provides needed medical or healthcare services to any person at a free medical clinic without compensation or the expectation of compensation due the inability of such person to pay for the services shall be immune from liability for any civil action arising out of the provision of such medical or health services.

(2). Immunity pursuant to subsection (1) of this section shall apply only if the healthcare provider and the patient execute a written waiver in advance of the rendering of such medical services specifying that such services are provided without the expectation of compensation and that the health care provider shall be immune as specified herein.

I certify that I have read and understand the above provisions of Title 39 of Idaho Statutes and that any questions I had concerning the above previsions were answered to my satisfaction.

______________________________ Date: __________________

Care Receiver Name

____________________________ Date: __________________

(If applicable) Guardian Name

_______________________________ Date: __________________

Witness

<u>NOTE:</u> A copy of Idaho Statues Title 39 – 7703 will be provided to you if you so desire. Mark here if you would like a copy of the statute. ➡ (Y / N)

X____

Signature of Care Receiver (or Guardian)