Providence
Medical Clinic of Kingsport

441 Clay Street; Kingsport TN 37660
Phone: (423) 247-4536 Fax: (423) 247-5676

Thank you for your interest in becoming a patient of Providence Medical Clinic of Kingsport. Providence Medical Clinic is a free, faith-based medical clinic located in downtown Kingsport, serving the uninsured of Sullivan County and the Greater Kingsport Area. The clinic offers compassionate medical and spiritual care to those in need, providing acute care, primary care with specialty clinics. Providence Medical Clinic's Staff of volunteer doctors, nurses, clerical and spiritual support are committed to excellence in medical care, love and compassion.

To become a patient of Providence Medical Clinic, you need to complete the attached application and bring it to the clinic, along with the required information listed below on any **Monday, Tuesday**, **Wednesday or Friday from 9:00am –1:00pm; no appointment is necessary to return the required information.**

--- PROOF OF INCOME FOR EACH PERSON WHO LIVES IN YOUR HOME, TO INCLUDE:

- Unemployment information and termination letter
- Copy of your most recent Federal Tax filing
- Last month of pay stubs from employer
- Disability Benefits
- Retirement Benefits
- Food Stamp Determination Letter
- Families First Benefits
- HUD Assistance

--- PROOF OF RESIDENCY: Please bring one of the following to show were you live:

- Copy of utility bill such as a home phone bill, water bill or a power bill, bank statement, car insurance statement, hospital bill, etc. that shows your name and current address on it.

--- LETTER OF SUPPORT:

- If living with a relative or friend, please bring a letter of support with name of the relative or friend, address, phone number, date and whether they are supporting patient financially and/or living expenses.

--- PROOF OF IDENTIFICATION:

- Driver's License, State ID, or Student ID

--- ELIGIBILITY APPLICATIONS: Please pick up or return eligibility applications for Providence on:

- **MONDAYS, TUESDAYS, WEDNESDAYS AND FRIDAYS FROM 9:00am-1:00pm**
- **YOU DO NOT NEED TO CALL AND MAKE AN APPOINTMENT**

FINANCIAL GUIDELINES: Patients must have a household income that falls within our eligibility guidelines. (Guidelines are listed on the back of this page.)

Thank you,
Providence Medical Clinic of Kingsport

Revised: 1/24/24

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Eligibility Guidelines

2024 Federal Poverty Level Income Guidelines

	100%	133%	138%	**150%**	200%	300%	400%
1	$15,060	$20,029.80	$20,782.80	**$22,590**	$30,120	$45,180	$60,240
2	$20,440	$27,185.20	$28,207.20	**$30,660**	$40,880	$61,320	$81,760
3	$25,820	$34,340.60	$35,631.60	**$38,730**	$51,640	$77,460	$103,280
4	$31,200	$41,496	$43,056	**$46,800**	$62,400	$93,600	$124,800
5	$36,580	$48,651.40	$50,480.40	**$54,870**	$73,160	$109,740	$146,320
6	$41,960	$55,806.80	$57,904.80	**$62,940**	$83,920	$125,880	$167,840
7	$47,340	$62,962.20	$65,329.20	**$71,010**	$94,680	$142,020	$189,360
8	$52,720	$70,117.60	$72,753.60	**$79,080**	$105,440	$158,160	$210,880

Revised: 1/24/24

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Patient Rights and Responsibilities:

- ✓ Staff and volunteers will treat all patients and their families with respect. Likewise, as a patient of PMCK, you are expected to treat the staff and volunteers with respect. **Abusive behavior will NOT be tolerated.**
- ✓ Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq. ("Title VI") Title VI **prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance.**
- ✓ Prior to becoming a patient at PMCK, you are required to submit a ***COMPLETED*** eligibility application WITH supporting documentation. Eligibility status is good for one full calendar year. Patients are responsible to inform the office if any aspect of eligibility changes and provide supporting documentation; example change of address-bringing in a new piece of mail OR change in income-bringing in a new check stub. Patients must renew eligibility each year or if changes occur. Failure to do so can result in the patient being ineligible to receive care.
- ✓ Each PMCK patient will receive an eligibility card. It is the patient's responsibility to present this card at each appointment and when picking up medications, either from the pharmacy OR the clinic.
- ✓ As a patient of PMCK, you have to right to decline any treatment or diagnostic, however if your refusal is in conflict with professional standards of care, your eligibility to receive services may be terminated.
- ✓ Providence Medical Clinic of Kingsport utilizes volunteers to serve our patients. Providers volunteer their personal time; therefore, scheduled appointments are limited. Patients are expected to keep their scheduled appointments or call at least 24 hours before the appointment to cancel. Failure to keep an appointment or cancel the appointment will result in a "NO CALL/NO SHOW." After 3 "NO CALL/NO SHOWS," your chart will be reviewed for compliance and you may be dismissed.
- ✓ As a patient of PMCK, you will receive your medical services at no charge. These services *may be* offered using Ballad Assistance. If Ballad Assistance is required it is the responsibility of the patient to provide ALL requested documentation in order to obtain said services. While PMCK will provide assistance in obtaining financial aid for patients to receive services outside of the clinic, at no time is PMCK responsible for a patient's medical bills.
- ✓ PMCK will also provide 5 free or $50 worth of medication a month. PMCK providers have the right to determine which medications will be covered if you require more than the 5/$50. Any additional medications will be written on a separate prescription. The patient is responsible for the cost of additional medications, as such you have the right to take this RX to find the most affordable option available.
- ✓ If a brand name medication is available via a Patient Assistance Program, the clinic will apply for aid on your behalf. Patients are responsible for providing any required documentation. Failure to provide the required documentation may prevent you from being able to receive the medication. Patients are also responsible for requesting these medications PRIOR to needing refills to ensure no lapse in treatment.
- ✓ As a patient you have a right to receive care while transitioning to a new clinic. Patients may transition due to increase in income, obtaining insurance, etc. PMCK will provide a 30day

transition period in these instances. You have the right to receive a 30day supply of medication and/or to be seen by PMCK providers during this transitional period.

- ✓ PMCK provides medication in 30 day supplies. While PMCK strives to provide quick and efficient responses to patient requests, it is the responsibility of the patient to notify PMCK of ANY refill request 48 hours prior to running out of medication.
- ✓ PMCK patients may have **LABS** drawn ***on any Tuesday or Friday from 9:00 am – 1:00 pm***.
- ✓ PMCK patients may pick up **MEDICATIONS** ***on any Monday, Tuesday, Wednesday or Friday from 9:00 am – 1:00 pm***.

Thank You for choosing Providence Medical Clinic of Kingsport. We look forward to serving you.

"This is My commandment, that you love one another as I have loved you"
John 15:12

DO YOU HAVE HEALTH INSURANCE? Yes____ No ____

Providence Medical Clinic of Kingsport
Patient Eligibility Application

REFERRED BY: ___ Holston Valley Hospital ___ Ballad Clinic ___ Indian Path ___ Other

If other, please state resource: _____

General Information: Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____City: _____St _____Zip_____

Date of Birth: _____ County of Residence: _____

Home Phone: _____ Work or Cell Phone: _____

Social Security Number: _____ **Race** __W__B__ Hisp __Other__

Gender: __ Male __ Female **Are you**: ____Married ____Single ____Widowed ____Divorced

Number of ADULTS **(age 18 or older)** living in your home **(including yourself): _____**

Number of CHILDREN **(under 18**) living in your home**: _____**

Where do you live: ____Own home ___ Rent ___ Relative ____Friend ___ Other: _____

Have you been staying with relative, friend or other, longer than 6 months? ___ How long:_____

If you are living with someone that is helping you, please bring a letter of support.
(It needs to be a couple of hand written lines, stating you are living with them, their name, address, date and phone number.)

_____

Emergency contact person: _____ Relationship to you: _____

Emergency contact phone number(s): _____

WE MUST HAVE AN ADDITIONAL PHONE NUMBER IN ORDER TO REACH YOU.

IF YOU DO NOT HAVE AN ADDITIONAL PHONE NUMBER, PLEASE SIGN AND DATE BELOW:

Patient signature: _____ Date: _____

EMPLOYMENT INFORMATION:

Employed: ___ Employer_____ Phone Number: _____
Unemployed: ___

Did you file an income tax return from the previous year (s)? _____ Yes ____ N
If yes, **please bring a copy of last year and previous year (if applicable)**
SPOUSE or FAMILY MEMBER YOU ARE CURRENTLY LIVING WITH:

Name: _____ Date of Birth: _____

____ Employed Employer_____ Phone Number _____

____ Unemployed

PLEASE LIST YOUR GROSS MONTHLY INCOME (BEFORE TAXES):

Patient Income	Spouse Income	Family Member's Income
Employment:	Employment:	Employment:
Social Security:	Social Security:	Social Security:
Disability:	Disability:	Disability:
Unemployment:	Unemployment:	Unemployment:
Child Support:	Child Support:	Child Support:
Families First:	Families First:	Families First:
Food Stamps:	Food Stamps:	Food Stamps:
Other Income:	Other Income:	Other Income:
Total Monthly Income:	**Total Monthly Income:**	**Total Monthly Income:**

ASSETS:

Own Home: Y or N Appraised Value: $_____ Mortgage: $_____

Own a Vehicle: Y or N Estimated Value: $_____ Mthly Payment: $ _____

Do you have a Checking Account: Y or N Balance:$ _____ If no, please sign below

- **Signature: _____ Date: _____**

Do you have a Savings Account: Y or N Balance: $ _____ If no, please sign below

- **Signature: _____ Date: _____**

Other: (401K, Retirement, Stocks, Trust) Y or N If yes, Amount or Value: $ _____

I certify that all information given is true and complete. I understand that if I have given false information or withheld information I may no longer be eligible for services at Providence Medical Clinic of Kingsport. I agree that this information may be used for other services as needed..

Applicant's Signature: _____ Date: _____

OFFICE USE ONLY …… DO NOT WRITE BELOW THIS LINE:

_____

Current Year Total Household Income: $_____
(Based on last 2 pay stubs or previous year income tax)

Total number of people living in the house: _____

Date Application approved: _____ Office personnel signature: _____ _

Date Application denied: _____ Reason: _____

Revised: 1/24/24