Operation Care
MERCY MEDICAL CLINIC

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Eligibility Application--Read this first!

Dear Prospective New Patient:

Mercy Medical Clinic is a Christ-centered free clinic staffed with volunteer medical providers. Our mission is to provide compassionate medical care to the uninsured and financially disadvantaged.

IN ORDER TO QUALIFY FOR CARE AT MERCY MEDICAL ALL OF THE FOLLOWING CRITERIA MUST BE MET:

1) Patients must not have any type of health insurance or medical coverage. *(Any exceptions must be approved by Clinic Director.)*
2) Patient must demonstrate financial need. Proof of income of all adults residing in the home must be provided. If patient states there is no income source then documentation explaining how the prospective patient is living without any source of income must be provided.

Please be aware of the following Mercy Medical Clinic policies:

a) We do not do pain management and we do not prescribe narcotics or pain pills. Please do not ask for them.

b) Being a patient at Mercy Medical is a privilege and there are many who desire to be patients. Our volunteer medical providers may recommend that a patient make changes in their lifestyle in order to be healthier. If a patient demonstrates a lack of such commitment, it is possible that medical services will be offered to others who are willing to make the necessary adjustments to their lifestyle.

c) In order to make sure patients truly desire our services **there is a limit of 3 "no-shows". After 3 missed appointments in which the patient failed to notify us ahead of time the patient will be dismissed from our clinic.** We believe "no-shows" demonstrate a lack of concern for others, both for our volunteer medical providers, and for other patients who could have been here at the time of the missed appointment. Once a patient makes an appointment, they are responsible for being present, regardless of whether they receive a courtesy reminder phone call from us or not.

d) A co-pay of $10 is requested and expected, paid in advance for visits with a medical provider (MD, Nurse Practitioner, PA, Physical Therapist…). Lab costs are separate. Lab work must be scheduled when the patient is able to pay for the particular blood tests needed. These costs are minimal, and we are grateful for Quest's generosity in providing their services at a substantial discount to our patients.

If you believe that you meet the above qualifications and would like to submit an application, please fill out the following form and include copies of the requested documentation along with $10. You may mail or drop off the

application at the clinic during office hours, Monday-Thursday 9AM-4PM. (As closing times vary, call first.) If mailed, do not send cash.

Incomplete applications will not be processed. Complete applications will be processed as space becomes available in the clinic. No appointment will be made for a new patient until the application is processed and approved.

Please note:

1) If your phone number changes after submission of your application you must notify us of your new number. If the phone number included in the application is disconnected or inactivated when we attempt to contact you for the first appointment, the application will be discarded.

2) If an appointment is made for you, your $10 will be applied to your first appointment's co-pay. If you do not come for your first appointment, you will lose the $10 co-pay.

3) If it is deemed that you do not qualify as a patient, then your $10 will be reimbursed.

4) Cancellation or No-Show Policy

   If you need to cancel your appointment, you must call the day before your appointment by 4pm to cancel. If no one answers the phone and it is before 4pm, please leave a voice mail message. Voice mails that are received before 4pm will be accepted as a cancellation. You will be charged $10.00 if you **miss, don't show, or cancel your appointment the same day.** If you can NOT make it to your Saturday appointment, you must call the previous Thursday BEFORE 4:00pm. Our office is not open on Fridays, SO PLEASE DO NOT CALL ON FRIDAYS to cancel Saturday appointments. Thank You.

   I have received this policy, and I understand that I may be charged $10 for cancelling the same day or missing my appointment.

   Signature_____ Date_____

Thank you, Clinic Director

REVISED FEBRUARY 2021

Eligibility Application

Please fill out this form completely. Include copies of the requested documentation.

Name _____ Date of Birth _____

Address _____

City _____State _____ Zip Code _____

Phone _____ Alternate Phone _____

Emergency Contact Name_____ Phone Number _____

Medical reason(s) for requesting an appointment: _____
_____

Checklist: Include copies of:

1) **Proof of Income:** Please provide past year Federal 1040 tax form. If this is unavailable, we will accept copies of the previous W-2 wage form or a recent paycheck stub from the past month for all adults living in the home. If unable, then a letter from the employers of all the adults living in the home will be accepted. If a letter from the employer is unable to be obtained, an Attestation of Income Form will be accepted. For adults without income, an Attestation of Zero Income for will be accepted along with a statement from the individual who is responsible for providing assistance for

2) **Photo ID:** A copy of a photo ID is required, regardless of address on the ID.

3) **$10:** Cash, check, money order, or cashier's check payable to Mercy Medical Clinic. The $10 will be returned if patient does not qualify. If an appointment is given, the $10 will apply as the co-pay for the first appointment.

4) **Proof of US residence:** driver's license, utility bill, lease, school record (anything with current US address on it is accepted)

_____

I attest that all the information that I have provided to determine my eligibility is complete and correct to the best of my knowledge. I solemnly declare that I am unable to obtain health and that I am not covered by any public health policy. I further agree to notify Mercy Medical of any changes in my income or insurance, or other factors used to determine my eligibility status. By signing the application, I authorize representatives of Mercy Medical to share this information with pharmaceutical companies' patient assistance programs or their designees as required for eligibility verification and audit purposes. I have read the accompanying information about Mercy Medical and agree to abide by the clinic policies if I am accepted as a patient.

I attest that the application information provided to determine assistance is true and accurate and that my Health Insurance is provider is:

☐ ACA ☐ Medicare ☐ Medicare Part D ☐ Medicaid ☐ VA ☐ NONE

_____

Signature Date

Mail or drop off this form, accompanying documentation, and check/money order to:

Mercy Medical Clinic
615 Washington St.
Shelbyville, KY 40065
(Clinic office hours are Monday-Thursday 9AM-4PM.)

Please answer the following questions as completely and honestly as possible

1. What is the total monthly household income? (This includes all contributors.)

   _____

2. How many people live in the home?

   _____

3. How many children/dependents are in the home?

   _____

4. Do you receive help from the government or any other agency to pay your rent or utilities?
   _____

5. What is your highest level of education?

   _____

Favor de contester las preguntas completamente y honestamente.

1. ¿Cuánto es el ingreso al mes para todas las personas en la casa?

   _____

2. ¿Cuántas personas viven en la casa?

   _____

3. ¿Cuántos niños/dependientes hay en la casa?

   _____

4. ¿Recibe usted ayuda del gobierno ó de cualquier otra agencia para pagar la renta ó los servicios públicos?
   _____

5. ¿A qué nivel llegó usted en la escuela?

   _____

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