Georgia Department of Public Health
Georgia Volunteer Health Care Program (GVHCP)
Patient Financial Eligibility Form

Clinic/Program/Provider: The Community Helping Place Free Clinic

SECTION I – PATIENT DEMOGRAPHIC INFORMATION

Patient Name:

_____

(Last Name) (First Name) (Middle Initial) (Nickname or Preferred Name)

Address:

_____

(Street) (City/State) (Zip Code) (County)

Telephone number: _____ **Secondary Telephone number:** _____

Date of Birth: _____ **Sex:** ☐ Male ☐ Female **Race/Ethnicity:**_____

SECTION II - INSURANCE INFORMATION/FINANCIAL ELIGIBILITY

Do you have insurance that covers? ☐ Health ☐ Vision ☐ Dental ☐ No Insurance

If you have insurance, what services/specialty does your insurance exclude?_____.

Do you currently have Georgia Medicaid? ☐ Yes ☐ No **Medicare Part B?** ☐ Yes ☐ No

I am: ☐ **Uninsured (no insurance)** ☐ **Underinsured (do not have coverage for services being sought)**

Your income must be at or below 200% of the Federal Poverty Level to be eligible to receive services under the GVHCP.

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

Please provide gross family monthly income from all sources: $_____.

SECTION III – LEGAL ACKNOWLEDGEMENTS

I understand that I am being referred to a volunteer health care provider who will provide care to me or to someone for whom I am legally responsible. My participation in this referral process is voluntary. The care I receive from the volunteer health care professional will be provided at no charge. I understand that the Volunteer is acting as an employee of the State of Georgia by treating me pursuant to the "Georgia Volunteer Health Care Program." I acknowledge that the exclusive remedy for any injury or damage suffered as a result of any act or omission of a health care provider acting within the scope of duties pursuant to that Program is a lawsuit under the State Tort Claims Act, O.C.G.A. § 50-21-20 *et seq*.

The information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge. I understand that any failure to update this information to the Department upon change in my financial or health insurance status may disqualify me from receiving health or dental care under the GVHCP. I further understand that making false statements or representations on this form may be punishable under O.C.G.A. Section 16-10-20 by a fine of not more than $1,000 or by imprisonment for not less than one or more than five years, or both.

Signature of Patient/Parent or Guardian | **Printed Name of Person Signing** | **Relationship to Minor (If applicable)**

Signature of Eligibility Specialist | **Printed Name of Eligibility Specialist** | **Date**