Volunteers in Medicine Chattanooga
5705 Marlin Road, Suite 1400, Building 5900
Chattanooga, TN 37411
Phone: (423) 855-8220 Fax: (423) 855-8230

Volunteers in Medicine provides medical care for uninsured residents of Hamilton County and some surrounding counties who can prove residence at their current address for a *minimum of three months* (90 days) and who meet certain financial guidelines. We require proof of individual income as well as total household income.

VIM requires the following documentation in order to be considered for acceptance as a patient:

- Current photo ID
- Piece of mail at least three months old (90 days old) addressed to you at your current address. This may be a rent receipt, utility bill, etc. No "junk mail" will be accepted.
- Most recent 2 statements for each account:
  Checking Savings Credit Union
- Copy of 2017 tax return with W2 form. If you did not file, bring a verification of non-filing letter from the Internal Revenue Service.
  This can be obtained online at www.IRS.gov, by calling 800-908-9946 to request by mail, or by calling 844-545-5640 to request an appointment at the local IRS office.
- If self-employed, Schedule C of the tax return is required.
- Most recent 4-6 pay stubs of all working adults in the household
- Food stamp letter
- If previously covered under TennCare, we require the TennCare drop letter.
- Documentation of Social Security Benefits. If you do not have your awards letter you can print it at www.ssa.gov.
- If employed full time or part time, bring a letter from your employer stating that you do not receive healthcare coverage through them.
- If you have no income, provide a written explanation of how you are meeting your living expenses. If someone is helping you with expenses we must have a letter from that person stating what they are providing and their relationship to you.

VIM Staff Notes:_____
_____
_____
_____
_____

Return the completed application **Monday through Thursday, 9:00 a.m. – 4:00 p.m.**

For established patients being rescreened: **Return application within 2 weeks from today's date**.

PATIENT INFORMATION:

Name:_____

Date of Birth:____/____/____ Social Security #:____-____-____

Home Address: _____
Street City State Zip

Home Phone:_____Cell Phone:_____

*If *you* do not have a working phone number, you must leave the name and number of someone we may contact*

Employer Name: _____

Employer Address:_____
Street City State Zip

SPOUSE INFORMATION:

Name:_____

Employer Name: _____

Employer Address:_____
Street City State Zip

HOUSEHOLD INFORMATION (List ALL persons in the household):

Name	Date of Birth	Relationship

MISCELLANEOUS HOUSEHOLD INCOME:

Unemployment benefits per month:_____

Food stamps per month:_____

Alimony/Child Support per month:_____

Social Security per month:_____

Disability benefits per month:_____

Workers compensation per month:_____

Pension income per month:_____

PATIENT MEDICAL INFORMATION

Name:_____

Do you have a medical history of:

HEPATITIS: _____ Yes _____ No
HIV / AIDS: _____ Yes _____ No

Where have you been receiving medical care prior to contacting Volunteers in Medicine? *This will be verified.*

Clinics:

_____Memorial Northshore Clinic
_____Memorial Community Health (Hixon)
_____Memorial Westside Clinic
_____Erlanger Dodson Avenue Clinic
_____Erlanger Southside Clinic
_____Homeless Health Center
_____Cherokee Health Systems
_____Fortwood Mental Health Center
_____Helen Ross McNabb Center
_____Joe Johnson Mental Health Center
_____Mental Health Cooperative
_____Lookout Mountain Community Health
_____Other: _____

EMERGENCY ROOMS VISITED (hospital and dates): _____

_____

HOSPITAL ADMISSIONS (hospital and dates): _____

HAVE YOU EVER UTILIZED PROJECT ACCESS? _____ Yes _____ No

If yes, when?:_____

DO YOU HAVE A TENNESSEE COVER RX DRUG PLAN?: _____ Yes _____ No

List ALL of your current MEDICATIONS and WHO prescribed them (Include over-the-counter medications. If more room is needed, use back of sheet.):

Medication	Dose	Who Prescribed
1.		
2.		
3.		
4.		
5.		
6.		

Please note: VIM physicians do not prescribe pain, anti-anxiety, or psychotrophic medications.

I have answered all questions honestly and completely. I understand that by submitting fraudulent or incomplete information my application may be denied.

SIGNED:_____DATE:_____

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CONSENT TO RELEASE/REQUEST MEDICAL INFORMATION

NAME:_____DATE OF BIRTH:_____

SS #: _____CONSERNING DATES OF SERVICE:_____

** I hereby authorize Volunteers in Medicine to request medical records from: **
Name:_____
Address:_____
City:_____State:_____Zip:_____

** I hereby authorize Volunteers in Medicine to release medical records to: **
Name:_____
Address:_____
City:_____State:_____Zip:_____

I authorize that all medical records or other information regarding my treatment, hospitalization, and/or outpatient care including psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including Acquired Immunodeficiency Syndrom (AIDS), or tests for HIV, Hepatitis C, or sexually transmitted diseases be released to Volunteers in Medicine. I further authorize that all of my medical records may be released to designated medical providers or agencies as required for continuity of my medical care.

I authorize the use of a faxed photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for the action already taken, may be voided in writing by me at any time. If I do not void this authorization it will automatically expire twelve (12) months after the date of signing.

Signed:_____ Date:_____
Print:_____