VOLUNTEERS IN MEDICINE, CHATTANOOGA, INC.
5705 MARLIN ROAD, SUITE 1400, BUILDING 5900
CHATTANOOGA, TN 37411
PHONE (423) 855-8220 FAX (423) 855-8230

Volunteers in Medicine (VIM) Chattanooga provides primary medical care for uninsured low income residents of the Greater Chattanooga area. Applicants must be able to show 90 day residency and meet certain income guidelines. **Income is based on total household income, not individual.**

VIM requires the following documentation to be considered for acceptance as a patient.

- ☐ **Photo Identification (applicant only)**
  Drivers license, passport, state identification card are all accepted.

- ☐ **Piece of mail 90 days old addressed to you at your current home address.**
  The mail should be a utility bill, rent receipt, or bank statement. Junk mail is not accepted.

- ☐ **Copy of 2019/20 tax return.**
  Any adult living in your household also must provide this information. If you (or someone else in your household) did not file, visit the IRS office for a Verification of Non-Filing Statement.
  If you are self-employed, provide a copy of your Schedule C.

- ☐ **Last four (4) paycheck stubs of *all working adults in your household.***

- ☐ **Last two (2) bank statements/credit union statements.**

- ☐ **If you are receiving:**
  _____ Alimony or child support, bring documentation of amounts you are paying or receiving.
  _____ Food stamps, bring your benefit letter.
  _____ Retirement or Pension Benefits, bring verification of these benefits.
  _____ Social Security benefits for a minor child, bring documentation of those benefits.

- ☐ **If you were dropped from TennCare within the past 12 months,** bring your TennCare drop letter.

- ☐ **If you are employed,** bring a letter from your employer stating you do not receive healthcare coverage through them.

- ☐ **If you have no income at all, provide a letter explaining how you are meeting your living expenses.**
  If someone is helping you with expenses (family member or friend), we need a letter from that person stating how they are helping you and your relationship to them.

Do you have a medical history of either:

- ☐ Hepatitis: _____ Yes _____ No HIV/AIDS:_____ Yes _____ No

Complete the attached forms and return with the above documentation on this date:_____

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Social Security #: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone:_____

Employer Name: _____

Employer Address: _____
Street City State Zip

Length of Employment: _____ Monthly Income: _____ Annual Income: _____

SPOUSE INFORMATION

Name: _____

Employer Name: _____

Employer Address: _____
Street City State Zip

Social Security #: _____ Monthly Income: _____ Annual Income: _____

HOUSEHOLD INFORMATION (LIST ALL PERSONS IN HOUSEHOLD)

Name	Date of Birth	Relationship

MISCELLANEOUS HOUSEHOLD INCOME

Unemployment Benefits per month: _____
Food Stamps per month:_____
Alimony / Child Support per month:
Paid: _____ Received: _____
Social Security / Disability Benefits per month: _____
Workers Compensation per month:_____
Pension Income per month:_____
Checking Account Balance:_____
Savings Account Balance: _____

PATIENT MEDICAL INFORMATION

Name: _____

Where have you been receiving medical care? *This will be verified.*

- ☐ Memorial Northshore Health Center
- ☐ Memorial Westside Health Center
- ☐ Erlanger Hospital Clinics
- ☐ Dodson Avenue Health Center
- ☐ Southside Health Center
- ☐ Homeless Health Center
- ☐ Cherokee Health Systems
- ☐ Helen Ross McNabb (Fortwood Center)
- ☐ Joe Johnson Mental Health Center
- ☐ Mental Health Cooperative

☐ Other, please list _____

Emergency Rooms Visited: _____

Have you ever utilized Project Access? _____ Yes _____No **If Yes, When:** _____

Do you have the Tennessee Cover RX Drug Plan: _____ Yes _____No

List all your current medications and who prescribed them. *Please note, VIM physicians do not prescribe pain, anti-anxiety, or psychotropic medications .If you need more room, please use back of sheet.*

Medication	Dose	Prescribing Physician

I affirm that I have answered all questions honestly and completely. I affirm that all documentation that I am providing is honest and complete. I understand that by submitting fraudulent or incomplete information my application will be denied. I understand that if in the future fraudulent or incomplete information is discovered in my application I may be inactivated as a patient.

_____

Applicant Signature Date