+ 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.**

--- 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 two 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 that has your name and address on it.

--- LETTER OF SUPPORT

- If living with a relative or friend please bring a letter of support: stating: name of relative/friend, address 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 9:00-1:00**
- **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

05/19/2021

Providence Medical Clinic of Kingsport
Eligibility Guidelines
150% U.S. Poverty Guideline
Federal Poverty Guidelines for FFY 2021– https://www.medicaidplanningassistance.org/federal-poverty-guidelines/)

ANNUAL 2021 FEDERAL GOVERNMENT POVERTY GUIDELINES

	100%	133%	138%	**150%**	200%	250%	300%	400%
1	$12,880	$17,130	$17,774	**$19,320**	$25,760	$32,200	$38,640	$51,520
2	$17,420	$23,169	$24,040	**$26,130**	$34,840	$43,550	$52,260	$69,680
3	$21,960	$29,207	$30,305	**$32,940**	$43,920	$54,900	$65,880	$87,840
4	$26,500	$35,245	$36,570	**$39,750**	$53,000	$66,250	$79,500	$106,000
5	$31, 040	$41,283	$42,835	**$46,560**	$62,080	$77,600	$93,120	$124,160
6	$35,580	$47,321	$49,100	**$53,370**	$71,160	$88,950	$106,740	$142,320
7	$40,120	$53,360	$55,366	**$60,180**	$80,240	$100,300	$120,360	$160,480
8	$44,660	$59,398	$61,631	**$66,990**	$89,320	$111,650	$133,980	$178,640
Add $4,540 for each person over 8								

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, address and their name.)

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: _____