ADMISSIONS APPLICATION:
MEDICAL SERVICES

QUALIFICATIONS
Bethesda Health Clinic serves hardworking low-income adults who are either uninsured or underinsured.

What is meant by "hardworking"?
If you have a paid job OR perform an important unpaid job such as being a caregiver, a volunteer or a participant in a self improvement program (ex: education, rehabilitation, etc), you could potentially qualify for care.

What is "underinsured"?
If you have insurance, but your deductible is high relative to your income, you could potentially qualify for care.

If you are unsure whether you would qualify for care, we strongly encourage you to come by the clinic anyway to speak with our admissions team. If you do not qualify, you will be referred to a patient advocate who can help you find other resources.

HOW TO BECOME A PATIENT
To become a patient, you need to meet with our admissions team to determine your eligibility.

1. You must appear in person at the clinic during admission screening hours.
2. Children are not allowed in the screening room. Please make arrangements ahead of time.
3. We do not always have a bi-lingual admissions consultant available. If you speak Spanish, please bring an English-speaking interpreter.

RECOMMENDED DOCUMENTATION TO BRING
The documentation you will be required to provide depends on your individual situation. If the following are available, we strongly encourage you to bring a paper copy of these during your initial visit.

1. Completed application and waiver forms
2. A current government-issued picture ID
3. If applicable or available, a recent paystub dated within the last 30 days.
4. If applicable or available, pages 1 and 2 of your latest filed tax return (form 1040)

This is a list of standard documentation, but based on your individual situation, you may be required to provide additional or different documentation. Your admissions consultant will help you determine what items you will need.

ADMISSION SCREENING HOURS
Monday – Thursday: 10am – 1:30pm
903.596.8353, ext 127

Date_____
Approved_____

Dismiss pol. disc._____
Enter _____
Scan _____

Co-pay _____

Initials _____

Language: English/Spanish

First Time **Returning**

Mr/Mrs/Ms First Name_____ M _____ Last Name _____

Date of Birth (month/day/year) ____-____-_____ Age _____ Sex (Circle one) Male Female

Street Address _____ City _____Zip _____

Daytime Phone where you receive voice mail (____) _____ Cell Phone (____) _____

Do you receive text messages: Y N E-Mail Address _____

Social Security Number #_____ Marital Status_____

Place of employment: _____

Texas Drivers' License # _____ - OR - Texas ID Number #_____

Mexico ID # _____

Race/Ethnic Origin _____

Emergency Contact Name, relationship, and phone # _____

***Circle the correct answer to each of the following questions*:**

Do you receive Medicaid? YES/NO Medicare? YES/NO Veterans' Benefits? YES/NO

Do you have any medical/health insurance coverage of any type? YES/NO

Are you currently receiving, or have you applied for Social Security Disability? YES/NO

Name of spouse and names & ages of children less than 18 years of age. (Use the back of the page if necessary.)

_____

_____

_____

What is the approximate total gross income (before taxes) for your family? $_____ per month

Who is the income provider? _____ (Proof of income is required for each.)

How did you hear about Bethesda? _____

I hereby declare that the above information is true and correct. I know that any false information could jeopardize my eligibility to receive medical attention at the Bethesda Health Clinic.

Legal Signature _____ Date _____

Bethesda
HEALTH CLINIC

WAIVER OF LIABILITY FOR TREATMENT

The medical treatment provided by Bethesda Health Clinic, a charitable non-profit organization (the "Clinic"), is provided by volunteer healthcare providers who do not receive compensation.

Texas Law (Texas Charitable Immunity and Liability Act of 1987 [as amended]), as well as Federal Law (Volunteer Protection Act of 1997), provides **IMMUNITY FROM CIVIL LIABILITY** for any act or omission resulting in death, damage, or injury if the volunteer was acting in good faith and in the course of his/her duties or functions within the organization.

By signing below, you acknowledge: (1) that the Clinic's volunteer healthcare providers (such as physicians, physician assistants, registered nurses, licensed vocational nurses, pharmacists, podiatrists, dentists, dental hygienists, optometrists, or any such persons who are retired or otherwise defined or included under Texas law or Federal law) are providing health care that is not administered for or in expectation of compensation; and (2) that there are limitations on you or your family's ability to recover damages from the volunteer or the Bethesda Health Clinic in exchange for your receiving health care services.

It is intended that this **WAIVER** be as broad and expansive as allowed by law.

ACKNOWLEDGEMENT OF LIMITATION OF LIABILITY:

TREATMENT WAIVER REQUIRED

_____	_____	_____
Printed Name of Patient or Patient's Authorized Representative	**Signature Name of Patient** or Patient's Authorized Representative	**Date**

_____	_____
Admissions Consultant	**Date**