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DEKALB COUNTY
Board of Health

Men's Health and Wellness Clinic Application

Thank you for your interest in the Men's Health and Wellness Clinic, operated by Ethnē Health and the DeKalb County Board of Health.

The clinic provides non-emergency primary care. This includes:

- Acute care
- Wellness exams
- Chronic disease management
- Labs and ultrasounds
- STD testing
- Follow-up and referrals

The clinic does not provide:

- Emergency care
- Trauma care
- Dental services

Ethnē Health is at 4122 E. Ponce de Leon Ave., Suite 5, Clarkston, Ga. 30021. It is open on Mondays through Thursdays from 9 a.m. to 5 p.m. and on Fridays from 9 a.m. to 12 p.m. Appointments are preferred; however, walk-ins are welcome.

To be eligible for services, patients must meet all these criteria:

- DeKalb County resident
- Male
- Age 18 or older
- Limited income
- Uninsured (no health insurance)
- Not eligible for Medicaid, Medicare, or veterans' benefits

To prove eligibility, you must complete this application and submit it with the required documents. See pages 4 and 5. You can submit your application and documents by:

- Fax to: (404) 294-3842
- Scan and email to: dekalb.ocdp@dph.ga.gov
- Drop off at: DeKalb County Board of Health, 445 Winn Way, Suite 354, Decatur, Ga. 30030
- Mail to: DeKalb County Board of Health, P.O. Box 987, Decatur, Ga. 30031

If you are approved, you will be contacted to schedule your first appointment. Your clinic visits will be free. Your medical costs will be covered by the Board of Health and other funders.

If you have any questions or need help with completing this application, call (404) 508-7847.

Clinic location: 4122 E. Ponce de Leon Ave, Suite 5, Clarkston, Ga. 30021

Supporting Documents

Please submit a copy of the following REQUIRED documents with this application!

☐ One valid picture government-issued identification (ID)

Examples:

- Driver's license
- Visa
- Passport
- Green card
- State-issued ID card
- IDs and passports issued by foreign governments

☐ One proof of residency

Official or business mail that shows your name and address

Examples:

- Rental lease
- Utility/cable bill
- Bank statement
- Notarized letter from landlord or roommate

☐ Proof of income

To document income we need to know about the members of your family/household who live together most of the time and depend on each other's incomes

- Include Proof of Income documentation for every family/household member age 18 and older
- Include Proof of Income for employed adults as well as unemployed adults

See attached Proof of Income page

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Proof of Income

- Wages/Paycheck: Past 30 days
  - Weekly: 4 Stubs
  - Bi-weekly: 2 stubs
  - Bank Statement
- Self-Employment & Odd Jobs Income
  - Schedule C of Most Recent Tax Return
  - 1099s
- Pension/Retirement & Social Security & Disability Income
  - Award Letters
  - Bank Statements
  - Social Security Office:
    - Ph: 800-772-1213
    - 401 West Peachtree Street Northwest Suite 2860, Atlanta, GA 30308
    - 3554 Covington Hwy, Decatur, GA 30032
- Food Stamps & Housing Vouchers & Other Public Services
  - Gateway.ga.gov
  - Award Letter
  - Letter from Public Facility verifying residency/income
- Alimony/Child support
  - Copy of Court Order
  - Obtain at Superior Court Office
    - 556 N. McDonough Street, Decatur, GA 30030
    - Ph: 404-687-3990
- Unemployment Income
  - Wage Inquiry Form (Has to be picked up in person)
  - WorkSource Dekalb
    - 774 Jordan Lane Building 4 Decatur, GA 30033

Application for Fee Discounts

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This Application for Fee Discounts determines whether you qualify to receive healthcare services at discounted prices. Please read the "Fee Discounts Overview" flyer and the instructions on this application for information that will help you decide who is considered a part of your Household/Family and what is considered as income.

For Office Use Only:

Household/Family Size: _____
Household/Family Annual Income: $_____

Date: _____ Initials: _____

You will need to fill out this application and provide updated proof of income documents each year, or whenever your Household/Family size or income changes. Please ask any of our Patient Services staff members to help you fill out this application or answer any questions, if needed.

☐ *Please check this box and sign below if you do not wish to share information about your income. If you do not complete this form, you will not be eligible for any fee discounts.*

Household/Family Size

Please list all members of your Household/Family who live together most of the time and depend on each other's incomes.

Head of Household / Responsible Party (must be the one completing this application)

	Last Name	First Name	Date of Birth
1			

Other Household/Family Members

	Last Name	First Name	Date of Birth	How is this person related to you?
2				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____
3				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____
4				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____
5				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____
6				☐ Spouse ☐ Child ☐ Partner ☐ Grandchild ☐ Other _____

Application for Fee Discounts

Household/Family Income

Please enter all forms of income (before taxes) earned by each member of your Household/Family, per month.

Household/ Family Member Name	Wages/ Paycheck	Self-Employment & Odd Jobs Income	Pension/Retirement & Social Security & Disability Income	Food Stamps Housing Voucher & Other Public Assistance	Alimony & Child Support	Unemployment Income	Support from Family/ Friends & Other Forms of Income	**Total**
							$	

Acknowledgements

Please initial below acknowledging that you understand each of the following:

_____ I have read and understand the "Fee Discounts Overview" and agree to follow its guidelines.

_____ I understand that I must provide the necessary proof of income documents to qualify for fee discounts.

_____ I will notify Ethne Health Services as soon as possible if the size or income of my Household/Family changes.

_____ Based on the information shared in this application and the assessment made by Ethne Health staff, I agree to pay the discounted fee required of me for each visit. I understand that the fee I have to pay may be different depending on the type of services I am receiving.

_____ I understand that I may be required to pay additional fees for certain laboratory testing, supplies/equipment, or for dental services not considered "basic", and that these amounts will be discussed with me prior to receiving services.

I affirm that all information provided in this Application for Fee Discounts is true and accurate to the best of my knowledge. I give appropriate Ethne Health staff permission to investigate any information provided in this application. I understand that providing false information will result in no longer being eligible for fee discounts.

_____ _____

Applicant's Signature Date

No-Show Policy Acknowledgement

Your healthcare providers want to make sure that you and other area residents have access to high quality medical and dental care when you need it. To ensure maximum access to care for all of our patients, please be aware of and follow the following Appointment/No-Show Policy.

Keeping Scheduled Appointments & Arriving Early

We will do our best to remind you of your upcoming medical or dental appointment by phone, mail, or email. But it is *your responsibility to remember your appointment date and time*.

You should arrive 15-30 minutes *before* your scheduled appointment time. If you cannot make it or think you will be late to your scheduled appointment, please let us know *as soon as possible*. If you are having a hard time finding transportation, please let us know. We might be able to connect you to resources that can help.

What is considered a "No-Show"?

- If you arrive more than 15 minutes after your scheduled appointment time, or
- If you do not call to cancel or reschedule your appointment *before 3pm the day before your appointment*.

What happens when I "No-Show" my appointment?

When you don't come to your appointment, you take an appointment time away from someone else who could have used it. **Because there are so many people in our community who do not have access to quality medical and dental services, *"No-Shows" are taken very seriously*.**

New Patients:
If you No-Show your first medical appointment, you may be given one more chance to schedule an appointment. If you No-Show that appointment, you will not be allowed to schedule another appointment for one year.

Established Patients:
If you No-Show 2 or more appointments in a 12-month period, you may lose your privilege to schedule appointments in the future. Depending on the situation, your medical or dental provider may allow you to still make appointments. These appointments might be "Same Day" appointments. If you show that you can keep appointments regularly, you may be allowed to make regular appointments again.

Patients under age 18 may be granted an exception to the No-Show Policy at the discretion of a medical or dental provider.

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Patient Name	Last	First	Middle Initial	Date of Birth

Home Address	House #	Street	Apt #	City	State	Zip

Email Address

Cell Phone: ( )	May we leave a voicemail? (circle one) Yes | No May we send a text message? (circle one) Yes | No

Gender: Female | Male	**Social Security #:** - -

Responsible Party: [ ] **Self**
[ ] **Other**: (Name) _____(Date of Birth) _____(Relationship to patient)_____

Additional Information
Please circle one option for each question below. We are required to ask these questions, but you may skip any you are not comfortable answering.

Marital Status? Single | Married | Partner | Widowed | Divorced | Legally Separated
Employment Status? Full-time | Part-time | Not Employed | Self-Employed | Retired | Active Military | Student

Race? American Indian/Alaska Native | Asian | Native Hawaiian/Other Pacific Islander | Black/African American | White/Caucasian
Ethnicity? Hispanic/Latino | Not Hispanic/Latino
Do you require interpretation services? Yes | No **Primary Language?** _____

Are you a veteran? Yes | No
Are you a public housing resident? Yes | No **If yes, which housing development?**
Are you homeless? Yes | No **If yes, what is your status?** Street | Doubling Up | Transitional Housing | Shelter | Other

Is your main employment in agriculture on a seasonal basis (Seasonal Agricultural Worker)? Yes | No
Do you move (migrate) through the year for agricultural work (Migratory Agricultural Worker)? Yes | No

Sexual Orientation? Straight/Heterosexual | Lesbian or Gay | Bisexual | Other | Don't Know | Choose not to disclose
Gender Identity? Male | Female | Transgender/Female-to-Male | Transgender/Male-to-Female | Other | Choose not to disclose

How did you hear about Ethne Health? _____

Acknowledgements

1) I voluntarily consent to receiving services at Ethne Health. I give permission to all Ethne Health Providers (physicians, physician assistants, nurse practitioners) to use diagnostic and treatment procedures they deem necessary for proper medical management and treatment. I understand that physician's assistants and nurse practitioners are not licensed physicians and may provide medical care only under the supervision and direction of a licensed physician.

2) I assign the payment of claims on my behalf to Ethne Health. I understand that some of the services I receive may not be covered by my third-party payor (Medicare, Medicaid, other insurance), and that I am responsible for paying these amounts.

3) I understand that payment in full is expected before I receive services at Ethne Health. This includes payment of all service fees, copays, and/or coinsurance amounts as discounted based on my fee discount eligibility.

4) I understand that Ethne Health will not write prescriptions for narcotics at a patient's first appointment. I further understand that Ethne Health Providers do not guarantee that they will continue a narcotic prescription.

5) I understand that Ethne Health may discharge me as a patient for cause, or if I do not see a Provider at Ethne Health in a 3 year time period.

I affirm that all information provided in this Patient Information form is true and accurate to the best of my knowledge.

_____ _____ _____

Signature of Patient or Patient's Parent/Guardian | Printed Name of Patient or Patient's Parent/Guardian | Date

Protection of Health Information (PHI)

Patient Name Last	First	Middle Initial	Date of Birth

Ethne Health is allowed to share the Patient's Protected Health Information (PHI) with only the people you list below. This PHI includes but is not limited to the Patient's health history, list of medicines, and lab results. These people will also be allowed to pick up the Patient's prescriptions.

First Name	Last Name	Phone Number(s)	Relationship to Patient	May we leave a message on this person's phone?	Should we call this person in case of an emergency?	Can this person give permission to treat the patient (if under 18)?
				Yes | No	Yes | No	Yes | No
First Name	Last Name	Phone Number(s)	Relationship to Patient	Yes | No	Yes | No	Yes | No

Note: If the patient under age 18, please include parents/guardians in this list.

By signing below I affirm that:

- *I have been given the chance to review the Notice of Privacy Practices.*
- *I give permission for Ethne Health to use and to share the Patient's PHI with necessary third-parties for payment, for treatment, and for general healthcare operations.*
- *I give permission for Ethne Health to share the Patient's PHI and to release the Patient's prescriptions to each of the people listed in the table above.*
- *I understand that I have the right to restrict how Ethne Health shares PHI and I can cancel this permission any time.*
- *I have read, understand, and agree to abide to Ethne Health's No Show Policy*

_____ _____ _____

Signature of Patient or Patient's Parent/Guardian | Printed Name of Patient or Patient's Parent/Guardian | Date