Church Hill Medical Mission
P.O. Box 166 · Church Hill, TN 37642
Phone: (423) 256-2408 · Fax: (423) 256-2426

Dear Patient:

Thank you for your interest in becoming a patient at the Church Hill Medical Mission. The medical mission is a faith-based clinic that provides free general medical care, prescription medications, and spiritual support to low-income, uninsured residents of Hawkins and Hancock Counties in Tennessee, and diabetes patients from Scott County, Virginia. We are able to provide these services because of the generous volunteer support of local medical providers and financial support from area churches, organizations, and individuals.

To become a patient at the Church Hill Medical Mission, you need to complete the attached application and bring it to the clinic, along with the required information listed below, on the 1st Thursday of each month from 10 a.m. to 2:00 p.m., no appointment necessary. If the 1st Thursday of the month is a holiday, we will process applications on the very next Thursday. On the back of this page is a list of dates of when we will be processing patient eligibility applications.

PLEASE NOTE: IF YOU DO NOT BRING THE INFORMATION OUTLINED BELOW, YOUR APPLICATION WILL NOT BE PROCESSED.

REQUIRED INFORMATION/DOCUMENTS INCLUDE:

⇨ **PROOF OF INCOME FOR EACH PERSON WHO LIVES IN YOUR HOME, TO INCLUDE:**

- Copy of your most recent federal tax filing
- Last two pay stubs from employer
- Unemployment Information
- Disability Benefits
- Retirement Benefits
- Food Stamp Determination Letter
- Families First Benefits

⇨ **PROOF OF RESIDENCY:** Please bring one of the following to show where 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.

⇨ **INSURANCE CARD IF YOU HAVE INSURANCE**

⇨ **PROOF OF IDENTIFICATION:**

- Driver's License, State ID, or Student ID

FINANCIAL GUIDELINES: Patients must have a household income equal to or less than the financial guidelines listed on the back of this page.

If you have any questions or need further information about our services, please call our office at 423-256-2408, Monday through Friday from 10 a.m. – 5 p.m.

Sincerely,
Tammy Brown
Clinic Manager

EPLOYMENT INFORMATION:

SELF (ADULT #1)

I am: ☐ Employed Employer:_____ Occupation:_____

☐ Unemployed Date unemployment started: _____

☐ Retired ☐ A Student Name of school: _____

☐ Disabled ☐ Receiving disability

SPOUSE OR OTHER ADULT HOUSEHOLD MEMBERS:

ADULT #2: Age: _____

Name: _____

☐ Employed ☐ Unemployed

☐ Retired ☐ Disabled

☐ A Student

Name of school: _____

ADULT #3: Age: _____

Name: _____

☐ Employed ☐ Unemployed

☐ Retired ☐ Disabled

☐ A Student

Name of school: _____

Income from **SELF (Adult #1)**	Please list all sources of income	Income from **ADULT #2:**	Please list all sources of income	Income from **ADULT #3:**	Please list all sources of 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:		**Total:**		**Total:**	

I certify that all information given on this application is true and complete. I understand that if I have knowingly given false information or withheld information on purpose, I will not be eligible for services at the Church Hill Medical Mission

Applicant's Signature: _____ **Date:** _____

.....OFFICE USE ONLY.....

Current Year Total Household Income: $_____ Accepted as Patient?: __Y __N

Tennessee CoverRx
Magellan Health Services
P.O. Box 1808
Maryland Heights, MO 63043
Fax: 1-800-424-5766

☐ NEW APPLICATION ☐ RE-ENROLLMENT APPLICATION ☐ CHANGES TO EXISTING APPLICATION

Please note: All fields must be completed (unless noted as optional) or application will be returned. Please see above to mail or fax completed form.

LAST NAME	FIRST NAME	MI

GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
☐ Male ☐ Female	– –	

# OF PEOPLE IN HOUSEHOLD	YEARLY HOUSEHOLD INCOME *(PLEASE ENTER AN AMOUNT)*	HOME PHONE NUMBER *(WRITE N/A IF YOU DO NOT HAVE A PHONE)*
		– –

EMAIL ADDRESS	CELL PHONE NUMBER *(WRITE N/A IF YOU DO NOT HAVE A PHONE)*
	– –

BY SIGNING BELOW, YOU AGREE TO RECEIVE TEXT-MESSAGES SENT TO THE PHONE NUMBER LISTED ABOVE ABOUT COVERRX.
YOU MAY OPT OUT OF TEXT MESSAGES UPON RECEIPT OF FIRST MESSAGE.

HOUSE ADDRESS	CITY	STATE	ZIP	COUNTY

MAILING ADDRESS *(IF DIFFERENT FROM ABOVE)*:	CITY	STATE	ZIP	COUNTY

RACE *(FOR TITLE VI PURPOSES)*:		LANGUAGE SPOKEN (OPTIONAL)
☐ Black	☐ American Indian or Alaskan	☐ English
☐ White	☐ Hispanic	☐ Spanish
☐ Asian or Pacific Islander	☐ Other:	☐ Other:

☐ Yes	☐ No	ARE YOU A U.S. CITIZEN OR QUALIFIED LEGAL ALIEN?
☐ Yes	☐ No	HAVE YOU LIVED IN TENNESSEE FOR AT LEAST THE LAST SIX MONTHS?
☐ Yes	☐ No	DO YOU HAVE HEALTH INSURANCE (INCLUDING TENNCARE)?
☐ Yes	☐ No	DO YOU HAVE ANY PRESCRIPTION DRUG COVERAGE OTHER THAN COVERRX? THIS INCLUDES MEDICARE, TENNCARE OR DRUG COVERAGE PROVIDED BY YOUR EMPLOYER. (DISCOUNT DRUG PROGRAMS OR PATIENT ASSISTANCE PROGRAMS PROVIDING FREE OR LOW-COST MEDICATIONS DO NOT COUNT.)
☐ Yes	☐ No	DO YOU HAVE MEDICARE (ANY PART INCLUDING A, B, C, OR D)?
☐ Yes	☐ No	ARE YOU HOMELESS OR LIVING IN A SHELTER? *(OPTIONAL)*
☐ Yes	☐ No	ARE YOU EMPLOYED (INCLUDING SELF-EMPLOYED)? *(OPTIONAL)*
☐ Yes	☐ No	DO YOU WORK 20 HOURS OR MORE IN A SEVEN DAY WORK WEEK? *(OPTIONAL)*

Terms and Conditions

While you are in CoverRx, you must follow the program rules. By signing the front of this form, you agree that:

You will pay your co-pay for each prescription filled.

You will notify CoverRx by submitting an updated application when:

- You move to a new address
- Your household income changes significantly
- The number of people in your household changes
- You have other prescription drug coverage

Form Number
TNCX0619

You will help with any investigations. CoverRx may ask you for proof of your household income. CoverRx may also ask you to provide proof that you live in Tennessee and/or that you are a U.S. citizen or qualified alien. You agree to provide this information to CoverRx. If you do not help, then you could lose your pharmacy assistance.

You allow CoverRx to get information about you. I understand that I have certain privacy rights with respect to my medical information under the Health Insurance Portability and Accountability Act (HIPAA), CFR Parts 160 and 164 ("Privacy Rule"). The Privacy Rule permits CoverRx to use and disclose my protected health information for purposes of treatment, payment and health care operations, including determining my eligibility for benefits.

You can report fraud or abuse. If you suspect someone of fraud or abuse please call Magellan Health Services at 1-800-424-5815.

Authorization: I want to apply for CoverRx pharmacy assistance. By signing below, I certify that the information contained in the application is true and accurate. I know that if I give any false information, I may be breaking the law. I know that CoverRx will check my information. I agree to help with any investigations. I also agree to follow the rules for the CoverRx program. I have read and understand these rules, which are on the back of this form.

Signature: _____ Date: _____

Rev: June 2019

Tennessee CoverRx
Magellan Health Services
P.O. Box 1808
Maryland Heights, MO 63043
Fax: 1-800-424-5766

Eligibility

To be eligible to participate in CoverRx, you must meet the following eligibility guidelines:

- Age 19 through 64
- Household income must be below the FPL income guidelines listed below
- U.S. citizen or qualified alien
- Tennessee resident for at least the last six months
- No prescription drug coverage including TennCare or employer-sponsored drug coverage. (Discount drug programs or patient assistance programs providing free or low cost medications do not count.)
- Cannot have Medicare (any part including A, B, C or D)

How Much You Will Have to Pay

If you are enrolled, CoverRx will help you pay for up to five prescriptions each month. Diabetic supplies and insulin do not count toward the prescription limit. You must pay a small co-payment for your first five prescriptions each month. (Note: A 90-day prescription will count as one prescription per month for three consecutive months.) Co-pay ranges are listed in the table to the right.

Co-payments are subject to change.

Type of Prescription	*What You Will Pay*
First five (5) prescriptions per month of Drugs on the *CoverRx Covered Drug List*. Diabetic supplies and insulin do not count against the five (5) script limit.	*Generic Drugs:* 30-day = $3 *90-day = $5 *Brand Drugs:* 30-day = $5 *Insulin/Diabetic Supplies:* 30-day (or up to covered limits) = $5 *90-day supplies are only available through mail order and those local retail pharmacies that have chosen to participate.
• Drugs NOT on the *CoverRx Covered Drug List* • ALL prescriptions after the five (5) prescription per month limit	Full price (price varies by drug), plus any pharmacy discounts available.

- You can purchase your prescriptions at participating local community retail pharmacies and mail-order pharmacies.
- Upon enrollment in CoverRx, a welcome packet will be sent to you with information about how to use the program.

Income Guidelines

To qualify for the CoverRx program, your yearly household income must be below the FPL levels listed in the table to the right.

Based on 2019 federal poverty guidelines. For families/households with more than 8 persons, add $6,099 for each additional person.

Persons in Household	Yearly Household Income
1	$17,236
2	$23,336
3	$29,435
4	$35,535
5	$41,635
6	$47,734
7	$53,834
8	$59,933

Contact Information

Mail or fax completed form to: **Tennessee CoverRx**
Magellan Health Services
P.O. Box 1808
Maryland Heights, MO 63043
1-800-424-5766 (Fax)

For questions about enrolling in CoverRx: 1-800-424-5815 (Phone)

Definitions

"Discount" means a price reduction offered to participants for certain prescriptions.

"Household Income" is the combined income of all household members 18 years old and over who maintain a single economic unit, as well as any income received by the household for the personal medical and other obligations of the participant(s) in the household.

"Household" is comprised of all persons living in the same residence maintaining a single economic unit.

"Qualified alien" means that you are not a U.S. citizen, but you live in the United States legally. To be a qualified alien, you must also meet other conditions. These conditions are defined in the federal law at 8 U.S.C. § 1622(b). If you are not a U.S. citizen or qualified alien, then you cannot enroll in CoverRx.

Rev: June 2019

Tennessee CoverRx
OptumRx, Inc.
P.O. Box 2135
Mission, Kansas 66201
Fax: 1-800-424-5766

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Signature: _____ Date: _____

Rev: July 2019