PRN_____

PRE-SCREENING TOOL

Name:_____ **Date of Birth:**_____/_____/_____

As you answer the following questions, please keep in mind that Grace Clinic operates as a Free Clinic and has limited resources. We are staffed mostly by volunteers and do not provide many of the services offered in a typical medical, dental or counseling office. Because of this, we do not treat the following conditions:

- Chronic Pain
- New or Ongoing Cancer Treatment
- Blood Clotting Disorders
- Routine Pap Smears
- Hormonal Disorders
- Other conditions as determined by our medical provider(s)

Additionally, we do not prescribe or dispense controlled substances or narcotics.

We also do not prescribe or dispense the following mental health medications: Ambien, Adderall, Lithum, Ritalin, Xanax, Valium or other medications similar to these.

If you have any of these conditions or use these medications, please stop here & notify the receptionist.

1. Are you living in one of these cities/towns on a permanent basis?

Basin City	Finley	Mesa	Richland
Benton City	Highland	Pasco	West Pasco
Burbank	Kahlotus	Paterson	West Richland
Connell	Kennewick	Plymouth	Whitstran
Eltopia	Kiona	Prosser	

You must live in this area year-round to be a patient. Long-term visitors are not eligible.

2. (a) Do you have any type of medical, dental, vision or catastrophic care insurance?

Apple Health Plan	Indian Health Service	Medicare	Student Insurance
Private	Medicaid Coupon	Veterans Administration	

If you have any of the above, you are not eligible for services. (Exceptions may be made for those with an urgent dental need if you meet other eligibility requirements and are covered by Medicaid, Medicare, or VA insurance. If you have Medicare, you may also be eligible for counseling services.)

(b) When was the last time you had medical insurance? Year_____

(c) Are you currently in the process of getting medical insurance? Yes_____ **No**_____
If yes, what have you applied for and when?

_____

Thank you for coming to Grace Clinic!

Revised 2-2020

PRN_____

PRE-SCREENING TOOL

3. **Is your need for care the result of an accident from an "on the job injury, one covered under a Labor and Industries claim, or any other third party coverage such as automobile or homeowner's insurance?" Yes_____ No _____**

   If you answered "yes," you are not eligible for services.

4. **What is your current total household income for one month or year from all sources? (Household income includes: pay for work, child support, alimony, food stamps, cash assistance, Labor & Industry, unemployment & all other sources of income, etc.)**

   a. **Total Household Income_____ Circle one: Monthly Annually**

   b. **Number of People Living in Your Home_____**

   c. **How many children under the age of 18 live with you?_____**

      Ages of minor children_____

This table shows the current figures for 200% of Federal Poverty Level (subject to change).

Family Size	Gross Monthly Income	Gross Yearly Income
1	$2,127	$25,520
2	$2,873	$34,480
3	$3,620	$43,440
4	$4,367	$52,400
5	$5,113	$61,360
6	$5,860	$70,320
7	$6,607	$79,280
8	$7,353	$88,240

If your gross income exceeds the amount shown, you are not eligible for services.

5. **Have you received services in an emergency room in the past three years? Yes_____No_____**
   If yes, when: Month_____ Year_____

   Where: Lourdes Medical Center_____ Trios (Kennewick General Hospital)_____
   Kadlec Regional Medical Center_____ Other (specify) _____

Reason for your ER visit:_____

6. **Have you seen a medical provider (not the emergency room) within the past three years?**
   Yes_____ No _____ Name of Provider_____

   When? Month_____ Year_____

   Name of the Medical Provider_____

Please return this completed form to the reception desk. **Please be prepared to provide: your current photo identification (WA State photo ID preferred), proof of income as listed above, and bottles or packages of all current medications**.

Thank you for coming to Grace Clinic!

Revised 2-2020