Thank you for your interest in Bridges to Care. The purpose of this program is to provide access to affordable healthcare to Davidson County’s uninsured population.

To be eligible for Bridges to Care, you must:

- be uninsured (have NO form of health insurance)

AND

- live in Davidson County (Nashville area)

*You are eligible for Bridges to Care regardless of your income as long as you are an uninsured resident of Davidson County.*

To sign up for Bridges to Care, you must:

- Fill out the attached application packet (includes application, authorization and income/residency verification) and leave it with the person who provided the packet to you, mail it to Bridges To Care at 10 S. 6th St., Nashville, TN 37206, fax it to 760-2796 or bring it yourself to a Care Coordinator (call 760-2799 for locations).

- Have a conversation with a Care Coordinator either in person or on the telephone. The Care Coordinator will complete a brief patient assessment with you and help you select the most appropriate medical home. Please note: YOU WILL NOT BE ENROLLED IN BRIDGES TO CARE WITHOUT SPEAKING TO A CARE COORDINATOR (call 760-2799 to speak to a Care Coordinator).

- Provide Income and Residency Verification. You can do this in one of three ways: 1) attach it to your application package and return it to the person who provided the packet to you (See attached form for acceptable forms of verification), 2) take a copy to a Care Coordinator at one of our enrollment locations, 3) mail it to the Bridges To Care office at 10 S. 6th St., Nashville, TN 37206, or 4) fax it to 760-2796.

- Please call 760-2799 to find the enrollment location nearest you.

BRIDGES TO CARE IS NOT INSURANCE AND DOES NOT PAY MEDICAL BILLS.

*FOR MORE INFORMATION OR TO SPEAK TO A CARE COORDINATOR PLEASE CALL 760-2799*
Safety Net Consortium of Middle Tennessee, LLC

Application

The following information is required for participation in Bridges to Care. Please complete each item. If you do not understand any of the items, please ask for help.

<table>
<thead>
<tr>
<th>Name:</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s Maiden Name</td>
<td>Parent/Guardian Name (if patient is a minor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td>Apt. #</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Mailing Address (if different)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
<td>( )</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Name and phone number of person to contact in an emergency</td>
<td>( )</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Birth Date</td>
<td>month/day/year</td>
<td>Age</td>
<td>Sex</td>
</tr>
<tr>
<td>Hispanic?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Primary Language</td>
<td>Speak English?</td>
<td>Read and Write?</td>
<td></td>
</tr>
<tr>
<td>Years Lived In Nashville</td>
<td>Homeless?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Country of Origin</td>
<td>County of Current Residence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Number</td>
<td># in Family</td>
<td>Annual Family Income</td>
<td>Cash Assets</td>
</tr>
<tr>
<td>Family Status (check marital status and children's ages if any)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>Single</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Children</td>
<td>Children under 6</td>
<td>Children over 6</td>
<td></td>
</tr>
</tbody>
</table>

If you have children in your household for which you are the parent or guardian, please supply information about each child on the reverse side of this form.

This application cannot be accepted without a signed BTC patient release of information form. Please sign two BTC patient release of information forms. Give this completed application along with the release forms to the admission or check out desk.

If you have questions, call the BTC office at 760-2799. Thank you for participating in Bridges to Care.
Please provide this information for each child in your family household.

<table>
<thead>
<tr>
<th>Name:</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Birth Date</th>
<th>Age</th>
<th>Sex</th>
<th>Race (Circle One)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Black</td>
</tr>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Hispanic ?</th>
<th>Yes</th>
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<table>
<thead>
<tr>
<th>Primary Language</th>
<th>Speak English?</th>
<th>Read and Write?</th>
<th>Last Grade Completed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
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</table>
Income and Residency Verification Form

Please fill in the information requested and sign below. Be sure to also attach a copy of your income and residency verification.

First Name: ________________________ Social Security Number: __________________

Last Name: ________________________ Number in Family: __________

Income Amount: _____________ County of Residence: ____________________

Income Is: (Circle one) Income Verification Source: (Circle one)

- Annually Copy of Court Order (Child Support)
- Quarterly Employer Income Statement
- Monthly Bank Statement
- Weekly Check Stub from Employer
- Bi-monthly (24 pay periods/year) Labor and Workforce Development Statement
- Every Two weeks (26 pay periods/year) Government Program Award Letter
- Investment Statement
- Social Security Benefit Statement
- SSI/Disability Statement
- Tax Return from Previous Year
- Original Notarized Letter of Support

Residency Verification Source: (cannot accept expired documents)

- Driver’s License
- Voter’s Registration Card
- Mortgage Statement/book
- Homeowners/Renters Insurance
- Check Stub from Employer (addressed to you)
- Property Tax Statement
- Rent receipts
- Mail addressed to you (i.e., a utility bill)
- Original Notarized Letter of Support

I certify the above is true and valid information to the best of my knowledge.

Signature: _______________________________ Date: __________________________

Care Coordinator: _______________________________ Date: __________________________
Patient Assessment

How long has it been since you last visited a Doctor? (Circle one)

Never  1 to 12 Months Ago  More than a Year  Don’t Know

Do you have any existing medical conditions? If yes, please list them below? Yes  No

Are you currently taking or awaiting any medications/prescriptions? Yes  No
If yes, please list the medications/prescriptions:

Is there a clinic or doctor you normally go to when seeking medical care? Yes  No
If yes, please list the name(s) and/or clinic(s) you go to:

Have you ever been admitted to a hospital? Yes  No

1. Hospital: ________________  Reason: ____________  Date: ________
2. Hospital: ________________  Reason: ____________  Date: ________

What dentist/clinic do you normally go to for dental care, if any?

Do you have any existing dental problems? Yes  No  If yes, please list:

How long has it been since you last visited a dentist?

More than a Year Ago  6 to 12 Months Ago  Within the Past 6 Months  Never

When did you last have your teeth cleaned?

More than a Year Ago  6 to 12 Months Ago  Within the Past 6 Months  Never
When was the last time you had 4 or 5 drinks on one occasion?

Never    In the last Six Months    More Than 6 Months Ago

How often do you usually drink?

Never    Once a Week    Two or More Times a Week

Have you ever used illegal drugs or prescription drugs other than prescribed?

Never    Within the past Year    More than a Year Ago

Have you ever felt you ought to cut down on your drinking or drug use?

Yes    No

Have people annoyed you by criticizing/complaining about your drinking or drug use?

Yes    No

Have you ever felt bad or guilty about your drinking or drug use?

Yes    No

Have you ever had a drink or drug in the morning as an eye opener to steady your nerves or get rid of a hangover?

Yes    No

Have you ever been treated by a mental health professional (psychiatrist, psychologist or therapist) or prescribed medication for psychiatric or emotional problems?

Yes    No

Have you ever been prescribed medication for psychiatric or emotional problems?

Yes    No    If yes, what? ________________________________

Have you been troubled or bothered by psychological or emotional problems in the last thirty days?

Yes    No

Have you ever been so sad that you thought of taking your own life / attempting suicide?

Yes    No    If yes, when? ________________________________

Have you ever been so angry or resentful that you felt like hurting someone else?

Yes    No    If yes, when? ________________________________

Have you ever heard noises or voices or seen things that others said they could not hear or see?

Yes    No    If yes, when? ________________________________
By signing this Authorization, I, __________________________________, authorize member organizations of the Safety Net Consortium of Middle Tennessee, LLC, (hereinafter “Consortium”) to use or disclose my health information as described below.

• **Information that is covered by this Authorization.** Health information about me that is subject to this Authorization includes all health information about me that is created or received by member organizations of the Consortium, except for the following:

___________________________________________________________________________________

• **Entity authorized to use or disclose my health information.** Matthew Walker Comprehensive Health Center, Centerstone, Metropolitan Nashville General Hospital at Meharry, Meharry Medical College, Metropolitan Public Health Department, Comprehensive Care Center, United Neighborhood Health Services, Faith Family Health Center, Baptist Hospital, Buffalo Valley Treatment Center, Centennial Medical Center, Samaritan Recovery Community, Saint Thomas Health Services, Pathfinders Incorporated, Tennessee Christian Medical Center, Mental Health Cooperative, Southern Hills Medical Center, Foundations, Vanderbilt University Medical Center, Meharry-Vanderbilt Alliance, Interfaith Dental Clinic, Siloam Family Health Center, Skyline Medical Center, Summit Medical Center, LifeCare Family Services, ProHealth Nashville, First Response Center, and Catholic Charities of Tennessee (hereinafter “Providers”) are authorized to use or disclose health information about me.

• **Receiver of my health information.** All Providers are authorized to receive health information about me.

• **Purpose of use or disclosure of my health information.** Providers are authorized to use or disclose health information about me for the term of this Authorization for the purpose of sharing health information about me for Bridges to Care. Bridges to Care has established an electronic system for the purposes of receiving, storing, and sharing health care information among Providers in order to create a common medical record for me. Since Providers all participate in Bridges to Care, I am authorizing Providers to use, disclose, or receive my health information to or from Bridges to Care or other Bridges to Care providers for purposes of creating or accessing my common medical record.

• **Term of the Authorization.** This Authorization will remain in effect until the Bridges to Care program no longer serves uninsured persons or unless it is revoked by me.

I understand that once Providers discloses my health information to a third party, any redisclosures of my health information by such third party may no longer be protected under federal or state privacy laws. However, any recipient of information relating to substance abuse may be prohibited from disclosing this substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may at any time make a written request to Providers to inspect and/or obtain a copy of my health information and that Providers will within thirty (30) days of receiving this written request, either contact
me for a convenient time to inspect and/or copy my health information or provide me with copies or a summary of my health information. I understand that I may refuse to sign this Authorization at any time for any reason and that my refusal to sign this Authorization will not affect the commencement, continuation, or quality of treatment of me by Providers.

I understand that Providers will not sell or receive compensation for the use or disclosure of my health information.

I understand that I may revoke this Authorization at any time and that such revocation will not affect the commencement, continuation, or quality of treatment of me by Providers. In order to revoke my Authorization, I understand that I should obtain a Revocation Notice from the Bridges to Care Office at the Metro Public Health Department and submit a completed Revocation Notice to the Metropolitan Public Health Department. I understand I may also revoke this Authorization by submitting a request to revoke in writing to the Bridges to Care Office at the Metropolitan Public Health Department. This revocation will be effective immediately upon receipt of the Revocation Form or written request to revoke by Providers, except that the Revocation will not have any effect on action taken by Providers in reliance on this Authorization before it received the Revocation Form or written request to revoke.

I understand that I may contact the Bridges to Care Office at:

ADDRESS Metro Public Health Department; 311 23rd Avenue North, Nashville, TN  37203
PHONE NUMBER 615-340-5655
FAX 615-340-2110
EMAIL elliott.garrett@nashville.gov

I understand that this Authorization will remain in effect until its term expires or I submit a Revocation Form or written request to revoke to Providers at the address listed above.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. Accordingly, I knowingly and voluntarily authorize Providers to use or disclose my health information in the manner described above.

__________________________________________ ______________________
Signature of Patient            Date

If Patient is a minor or otherwise unable to sign this Authorization, please complete the information below:

__________________________________________ ________________________  ________________
Signature of Authorized Personal Representative      Relationship               Date

___________________________________________ ________________
Witness        Date

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO PATIENT