

**GEORGIA DEPARTMENT OF PUBLIC HEALTH  
 GEORGIA VOLUNTEER HEALTH CARE PROGRAM (GVHCP)  
 FINANCIAL ELIGIBILITY AND PATIENT REFERRAL FORM**



**CLINIC / PROGRAM / PROVIDER:** Center for Black Women's Wellness

**SECTION I – PATIENT / CONTACT / INSURANCE INFORMATION**

**Patient Name:**     
 (LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

**Address:**   
 (STREET) (CITY/STATE) (ZIP)

**Telephone/Contact number:**  **Name of contact if other than yourself:**

**Date of Birth:**  **Sex:**  Male  Female **Ethnicity:**  Hispanic  Non-Hispanic

**Race:**  White  Black  Asian /Pacific Islander  American Indian/Alaskan Native

**Do you have insurance that covers?**  Health  Vision  Dental  No Insurance

**Do you currently have Georgia Medicaid?**  Yes  No

**SECTION II - PATIENT ACKNOWLEDGEMENT – FINANCIAL ELIGIBILITY**

I acknowledge that I meet one of the following program eligibility categories as defined by program legislation:

\* Uninsured  \* Underinsured  Medicaid eligible  A client of Dept of Public Health, Dept of Human Services or Dept of Community Health

\*If you checked “Uninsured” or “Underinsured” above, you must be at or under 200% of the Federal Poverty Level to be eligible to receive services under the GVHCP. Please provide gross family earned and unearned monthly income: \$\_\_\_\_\_.

\* The information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge. I also acknowledge that failure to provide the Department with an update on financial or health insurance status upon change to this status may result in my inability to receive health or dental care under the GVHCP. I further understand that falsification of any information contained on this form constitutes a felony and is punishable by either a fine of not more than \$1,000 or imprisonment for not less than one or more than five (5) years, or both.

**SECTION III – PATIENT REFERRAL**

**NOTICE TO PATIENT:** You are being referred to a volunteer health care provider who will provide care to you or to someone for whom you are legally responsible. Your participation in this referral process is voluntary. The care you receive from the volunteer health care professional will be provided at no charge to you. The health care provider is providing care on behalf of the State of Georgia and serves as a State employee or officer. By acceptance of this referral, you acknowledge that the exclusive remedy for injury or damage suffered as a result of any act or omission of a provider acting within the scope of his or her duties as a participant in the GVHCP is by commencement of an action pursuant to the Georgia Tort Claims Act (O.C.G.A. § 50-21-20 et seq.). You further acknowledge that remedies for injury or damage suffered as a result of any act or omission of a provider acting outside the scope of his or her duties as a participant in the GVHCP shall be as provided for under general tort law or other applicable law.

**PATIENT ACKNOWLEDGEMENT:** I hereby acknowledge that I have read and understand the Notice provided in this section. I authorize examination, diagnostic procedures and treatment as deemed necessary by the doctor(s) or other health care professional(s) (and whomever he/she may designate as assistants). Please initial here:

**O.C.G.A. § 50-21-23** (a) The state waives its sovereign immunity for the torts of state officers and employees while acting within the scope of their official duties or employment and shall be liable for such torts in the same manner as a private individual or entity would be liable under like circumstances; provided, however, that the state's sovereign immunity is waived subject to all exceptions and limitations set forth in this article. The state shall have no liability for losses resulting from conduct on the part of state officers or employees which was not within the scope of their official duties or employment. (b) The state waives its sovereign immunity only to the extent and in the manner provided in this article and only with respect to actions brought in the courts of the State of Georgia. The state does not waive any immunity with respect to actions brought in the courts of the United States.

**O.C.G.A. § 50-21-25** (a) This article constitutes the exclusive remedy for any tort committed by a state officer or employee. A state officer or employee who commits a tort while acting within the scope of his or her official duties or employment is not subject to lawsuit or liability therefore. However, nothing in this article shall be construed to give a state officer or employee immunity from suit and liability if it is proved that the officer's or employee's conduct was not within the scope of his or her official duties or employment. (b) A person bringing an action against the state under the provisions of this article must name as a party defendant only the state government entity for which the state officer or employee was acting and shall not name the state officer or employee individually. In the event that the state officer or employee is individually named for an act or omission for which the state is liable under this article, the state government entity for which the state officer or employee was acting must be substituted as the party defendant. (c) A settlement or judgment in an action or a settlement of a claim under this article constitutes a complete bar to any further action by the claimant against a state officer or employee or the state by reason of the same occurrence.

**DISCLAIMER:** The selected statutes provided herein are NOT inclusive of all of the provisions in the Georgia Tort Claims Act (“the Act”) and, because the law changes frequently, may not represent the most current version of the law. As necessary, you should review the current version of the Act in its entirety. This document is provided for your information only and does not constitute legal advice. You should direct any questions regarding your rights and obligations under the Act to a licensed attorney.

\_\_\_\_\_  
**SIGNATURE OF PATIENT/PARENT OR GUARDIAN**                      **PRINTED NAME OF PERSON SIGNING**                      **RELATIONSHIP TO MINOR** (if applicable)

\_\_\_\_\_  
**SIGNATURE OF VOLUNTEER**                      **DATE**