Adams Compassionate Healthcare Network

REGISTRATION CHECKLIST

☐ **MANDATORY CRITERIA**

- ☐ Do not have health insurance
- ☐ Income is less than 300% Federal Poverty Guideline 2026 (see below)

Household size	Monthly income at 300% FPL	Annual income at 300% FPL
1	$3,990.00	$47,880.00
2	$5,410.00	$64,920.00
3	$6,830.00	$81,960.00
4	$8,250.00	$99,000.00
5	$9,670.00	$116,040.00
6	$11,090.00	$133,080.00
7	$12,510.00	$150,120.00

☐ **COMPLETED REGISTRATION FORM**

All fields must be completed

☐ **PROOF OF ADDRESS**

Provide one of the following:

- ○ Driver's License/Permit/Any State ID
- ○ Mailed letter (Utility bills/Bank statement/etc) with patient name and address
- ○ Lease
- ○ Parents' Drivers License/State ID (option for children)
- ○ School enrollment letter/Report card/School transcript (option for children)
- ○ Letter of Support from supporter (only if above is not applicable, attached)

☐ **PROOF OF IDENTITY**

Provide one of the following:

- ○ Driver's License/Permit
- ○ Passport/Visa/Green Card/Any state ID
- ○ School ID (only for children)
- ○ Parents' Drivers License/Passport/Visa/Green Card/State ID (required for children)
- ○ Birth Certificate (only for children and only if above is not applicable)

☐ **PROOF OF INCOME**

Provide one of the following:

- ○ Most recent Tax Return dated and signed on second page of Form 1040
- ○ One Month Pay-Stubs / Paycheck
- ○ Zero Income Statement (attached) with Letter of Support if applicable
- ○ SNAP letter / Unemployment benefit letter / Social Security benefit letter
- ○ Employment Termination Letter / VA TANF / Sec on 8 Housing / Pension Asylum
- ○ Refugee Status / Student Visa + University Enrollment Letter
- ○ Letter From Another Nonprofit Indicating Benefits
- ○ Letter Of Support From Parents (only for children)

Patient Signature: _____ **Date Submitted:** _____

Submit the application and all supporting documents by:

1. Email to **registration@achnhealth.org**

OR

2. Bring or drop a physical copy to ACHN clinic:
   4437 Brookfield Corporate Dr, Suite #109, Chantilly, VA 20151

REGISTRATION FORM

Adams Compassionate Healthcare Network

Are you a new patient?

☐ Yes, I am a new patient ☐ No, I am a returning patient updating my annual eligibility

IDENTIFICATION

First Name: _____ Last Name: _____ Middle Name: _____

Legal Sex: ☐ M ☐ F Date of Birth(mm/dd/yyyy): _____ SSN: _____

CONTACT

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Mobile Phone: _____ Consent to receive automated text? ☐ Yes ☐ No

Home Phone: _____ Consent to receive automated calls? ☐ Yes ☐ No

IF PATIENT UDER THE AGE OF 18 OR IF PATIENT HAS A LEGAL GUARDIAN

Parent or Guardian's name: _____ Parent or Guardian's date of birth: _____

Parent or Guardian's address: _____ City: _____ State: _____ Zip Code: _____

Parent or Guardian's phone number: _____ Parent or Guardian's email: _____

DEMOGRAPHICS

Preferred Language: _____ Do you need translator? ☐ Yes ☐ No

Race/Ethnicity: ☐ Black/African American ☐ Caucasian/White ☐ Hawaiian/Other Pacific Islander
☐ Native American/Alaska Native ☐ Middle Eastern/North African ☐ Hispanic/Latino
☐ Asian ☐ Other: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

How many people in your household? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ Other: _____

*Household income:*This information is required to ensure eligibility, please provide one below*

☐ Annually: $ _____ OR ☐ Monthly: $ _____

ADDITIONAL INFORMATION

Are you employed? ☐ Yes ☐ No *if yes, specify below*

☐ *Employed full-time* ☐ *Employed part-time*
☐ *Self-employed* ☐ *Seasonal worker*

Are you a student? ☐ Yes ☐ No

Are you a refugee? ☐ Yes ☐ No Who is the head of the household? ☐ Female ☐ Male

Are you homeless? ☐ Yes ☐ No

Have you recently lost your insurance? ☐ Yes ☐ No *if yes, specify below*

☐ *Medicaid* ☐ *Employer-sponsored insurance*
☐ *Marketplace insurance* ☐ *Other:* _____

EMERGENCY CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize ACHN Clinic to share my protected health information with the following individual listed below and they will also be added as my emergency contact:

Full name: _____ Relationship to patient: _____ Phone number: _____

By signing this form, I certify I am uninsured and meet the ACHN income eligibility requirement and that all information provided is true and accurate.

Patient/ Guardian Signature: _____ Date: _____

Patient/ Guardian Name: _____

OFFICE POLICY

Adams Compassionate Healthcare Network

GENERAL RULES

Treat staff, volunteers, and other patients with courtesy and respect. Wait times may vary, and your patience is appreciated. Please use cell phones respectfully and avoid disrupting others. We ask that you not bring children to appointments. If children must accompany you, they must remain with you at all times and may not disrupt others. ACHN reserves the right to refuse services to anyone who behaves inappropriately toward staff, volunteers, or other patients.

Patient's or Guardian initial here: _____

ELIGIBILITY

If you obtain health insurance or are currently insured, you may no longer be eligible for ACHN clinic services. Please notify us promptly of any changes to your insurance status.ACHN eligibility expires 12 months after registration or when your household income changes, whichever occurs first. You are responsible for renewing your eligibility annually and notifying ACHN of any changes to your address, phone number, household income, or household size. ACHN reserves the right to revoke services if it becomes aware of income changes that exceed the eligibility threshold.

Patient's or Guardian initial here: _____

APPOINTMENTS

Patients are responsible for remembering their appointments. Reminder calls, texts, and emails are provided as a courtesy only. Appointments are required; no same-day appointments or walk-ins. Arrivals more than 15 minutes late will need to be rescheduled and incur a $10 late fee. Cancellations must be made at least 48 hours in advance. Late cancellations and no-shows will incur a $10 fee at the next visit. After 2 consecutive no-shows or 2 consecutive cancellation within the same day, appointment eligibility may be revoked.

Patient's or Guardian initial here: _____

MEDICATION & RECORDS

Please bring all current medications, blood sugar logs, blood pressure logs, and relevant medical records to every appointment. All registered patients have access to the ACHN patient portal, available through www.achnhealth.org. All requests for appointments, prescription refills, tests, and other services must be submitted through the patient portal 3–4 business days in advance. If you are enrolled in a Medication Assistance Program, refill requests must be submitted at least 2 weeks in advance.

Patient's or Guardian initial here: _____

LAB COST & LOCATIONS

Any labs ordered by ACHN are done at a discounted rate. Any blood tests that are paid for at ACHN must be performed at ACHN Clinic or Sunrise Medical laboratories only. Lab charges are collected at ACHN. ACHN will not be responsible if labs are done at a facility other than an ACHN approved facility (Sunrise Medical Laboratories). If you pay at ACHN and go to another lab, ACHN will not be responsible and will not serve as a mediator.

Patient's or Guardian initial here: _____

REFERRAL & OUTSIDE CARE

Referral to specialist care may be provided within ACHN Clinic or through an external healthcare provider, based on the recommendation of an ACHN primary care provider and the availability of appropriate in-house specialists. If an external referral is required, the patient is responsible for coordinating and understanding the financial requirements of the outside provider. External providers may require out-of-pocket payment or may offer financial assistance programs, which patients should apply for in advance in accordance with the provider's policies. ACHN Clinic may assist patients with the financial assistance application process when available; however, ACHN is not responsible for any charges or costs incurred through external providers. ACHN does not cover or pay for services provided outside the clinic, including but not limited to urgent care, outpatient or inpatient services, hospital services, emergency medical care, or other specialty services. ACHN Clinic is not an insurance company and does not provide health insurance coverage.

Patient's or Guardian initial here: _____

CONSENT FOR TREATMENT AND SERVICE

By signing below, I consent to ACHN Clinic providers performing medically necessary examinations, diagnostic evaluations, and treatment as determined appropriate for my care. I authorize ACHN Clinic to use and disclose my protected health information (PHI) as permitted by law for treatment, payment, healthcare operations, and coordination of care, including communications and electronic or faxed information sharing with other healthcare providers. I acknowledge receipt of the ACHN Clinic Notice of Privacy Practices and understand my rights regarding my PHI. I consent to telehealth services when recommended and understand their potential benefits, limitations, risks, and confidentiality protections. I certify that the information I provide is accurate and authorize ACHN Clinic to verify my income and eligibility. I understand that I am responsible for applicable charges and that I may withdraw my consent in writing, subject to applicable law and prior actions taken in reliance on this consent. This consent remains effective while I receive care at ACHN Clinic unless and until revoked in writing.

Patient's or Guardian initial here: _____

Date: _____

Adams Compassionate Healthcare Network

PATIENT HISTORY FORM

Only to be filled by new registering patient.

Full Name: _____ Date of Birth: _____

Reason for Visit: _____

_____

ALLERGIES *(Please list all medications, food, or other allergies you may have)*

	Allergen	**Severity** (*mild, moderate, severe*)	**Reaction**
Ex.	*Tylenol*	*Moderate*	*Hives*

PHARMACY *(Please list your preferred pharmacies for prescriptions)*

Preferred Pharmacy Name: _____

Pharmacy Address: _____

CURRENT MEDICATION *(Please list all medications you are currently taking, including non-prescription drugs or supplements)*

	Medication name	**Dose**	**Frequency**
Ex.	*Vitamin C*	*1000 mg*	*1 tablet twice daily*

FAMILY HISTORY *(Please list history of all diseases or conditions that you have in your family)*

	Disease/ condition	**Relatives** *(father, mother, sibling, other)*	**Age of onset/diagnosed**
Ex	*Eczema*	*Mother & Sister*	*10 y.o & 5 y.o*

PAST MEDICAL HISTORY *(Please check all medical conditions that you have in the past)*

☐ Diabetes	☐ Eye Disease	☐ Tuberculosis
☐ High Blood Pressure	☐ Heart problems	☐ HIV/AIDS
☐ High Cholesterol	☐ Angina	☐ Stomach or peptic ulcer
☐ Thyroid Disease	☐ Anemia	☐ Kidney Disease
☐ Liver Disease	☐ Asthma	☐ Epilepsy
☐ Cancer	☐ Stroke	☐ Other : _____

PAST SURGICAL HISTORY *(Please list all past major surgeries or medical procedures that you have)*

	Surgery	**Year**	**Hospital/Location**
Ex	*Tonsil surgery*	*2011*	*Inova Fairoaks, US*

SOCIAL HISTORY

Do you or have you ever smoked tobacco?

◯ Never Smoke ◯ Former Smoker ◯ Current Everyday Smoker ◯ Current someday Smoker

Do you or have you ever used any other forms of tobacco or nicotine? ◯ Yes ◯ No

What is your level of alcohol consumption?

◯ None ◯ Occasional ◯ Moderate ◯ Heavy

Do you use any illicit or recreational drugs? ◯ Yes ◯ No

What is your level of caffeine consumption?

◯ None ◯ Occasional ◯ Moderate ◯ Heavy

What is the highest grade or level of school you have completed/ highest degree you have received?

select one

☐ Attended, no diploma ☐ High School diploma ☐ Bachelor's degree

☐ Some college, no degree ☐ Master's degree ☐ Associates degree

☐ Never attended ☐ Professional degree (MD, DDS) ☐ Doctoral Degree

☐ Do not know

Are you currently employed? ◯ Yes ◯ No

What is your relationship status?

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner ☐ Other ___

How many children do you have? _____

Have there been any changes to your family or social situation? ◯ Yes ◯ No

Do you have any pets? ◯ Yes ◯ No

Do you have smoke and carbon monoxide detectors in your home? ◯ Yes ◯ No

Are you passively exposed to smoke? ◯ Yes ◯ No

Are there any smokers in your house? ◯ Yes ◯ No

Are there any guns present in your home? ◯ Yes ◯ No

Do you use sunscreen routinely? ◯ Yes ◯ No

Are you able to care for yourself? ◯ Yes ◯ No

Are you blind or do you have difficulty seeing? ◯ Yes ◯ No

Are you deaf or do you have serious difficulty hearing? ◯ Yes ◯ No

Do you have difficulty walking or climbing stairs? ◯ Yes ◯ No

Do you have difficulty dressing or bathing? ◯ Yes ◯ No

Do you have difficulty doing errands alone? ◯ Yes ◯ No

Do you have transportation difficulties? ◯ Yes ◯ No

Please select which resources you would like to receive more information on:

☐ Basic needs (food/emergency financial assistance) ☐ Housing / Shelters

☐ Employment and career ☐ Financial education

☐ Senior care ☐ Substance use disorder

☐ Legal support / immigration ☐ Domestic violence

Adams Compassionate Healthcare Network

ZERO INCOME STATEMENT

To be filled if the patient has no income.
To be completed by the patient.

Patient name: _____ Patient's date of birth (mm/dd/yyyy): _____

I am signing this form to declare that I am currently **UNEMPLOYED** and **DO NOT HAVE ANY INCOME** from any source. I receive financial support from:

☐ **Family, friend, or outside source.**
(Please have your supporter fill out the Letter of Support)

☐ **Receive state benefits.**
This includes but not limited to: SNAP (for food only) / unemployment benefit/ social security benefit/disability benefit/ other states and federal benefits.
(Please submit recent proof of receiving these benefits)

☐ **Other:**
Explain your situation here

I agree to notify the clinic about any changes in my income within 30 days of the change.
I understand that by completing, signing, and dating this form, I declare I have no income and that the information I am providing is correct.

_____
Signature of person completing this form (patient)

_____
Date signed

LETTER OF SUPPORT

Adams Compassionate Healthcare Network

To be filled if the patient is receiving housing/food/living expense support from someone other than themselves.
To be completed by supporter.

Patient name: _____ Patient's date of birth (mm/dd/yyyy): _____

Do you (supporter) claim patient as a dependent on your tax return? ☐ Yes ☐ No

If yes, tax return must be provided

Type of support provided to patient and their family (complete all sections below):

Housing: Move in date: _____ Move out date: _____ or ☐ Still living here

Food and living expenses: Estimate average monthly support provided $ _____

I expect to provide this support until: _____

Name of person providing support: _____ Relationship to patient: _____

Address of person providing support: _____

Phone number of person providing support: _____

Email address of person providing support: _____

Attestation:

I certify that to the best of my knowledge, the above information is true and correct. I agree that you may contact me if further verification is necessary.

_____
Signature of person completing this form (supporter)

_____
Date signed