WellnessPointe
Family Health Starts Here

1107 E. Marshall Ave Bldg #2.
Longview, TX 75601

1711 S. Henderson #400
Kilgore, TX 75662

602 N. Titus St #130
Gilmer, TX 75644

903.758.2610

To qualify for Department State Health Service (DSHS) Programs Title V, Primary Health Care, Breast and Cervical programs, and Sliding Scale Assistance:

An appointment must be made to be screened for these program services and assistance.

Bringing all information does not guarantee eligibility for the programs

5. **Identification for yourself, spouse and/or partner** *(whether married or living together)*, **and birth certificates for all of your minor child(ren)** ***(one of the following):***
   - **A.** Valid ID card
   - **B.** Birth Certificate(s)
   - **C.** Permanent Resident Card
   - **D.** Valid Driver's License
   - **E.** Valid Passport
   - **F.** Voter ID card / Consular ID

6. **Proof of Income** *(All of the following)* ***(If spouse and/or partner's income used he/she must schedule an appointment to sign paperwork)***
   - **A.** One month most recent consecutive pay stubs (i.e. paid monthly-one check stub, paid bi-monthly-2 check stubs, paid bi-weekly – 2 check stubs, paid weekly-4 check stubs)
   - **B.** Child Support and Alimony Payments
   - **C.** Social Security (Award Letter)
   - **D.** Unemployment
   - **E.** Worker's Compensation
   - **F.** TANF benefits
   - **G.** Other Income: regular payments, strike benefits, veteran's benefits, pension payments, annuity payments, dividends, interest, rents, royalties, tax return, payments from estates and trusts, etc.

7. **Proof of Address** (Bills must be with *physical address and within* last 30 days)
   - **F.** Valid Driver's License
   - **G.** Utility Bill
   - **H.** Rent/Lease Agreement
   - **I.** Mortgage Statement
   - **J.** House Title
   - **K.** Property Tax Statement
   - **G.** Bank Statement
   - **H.** Letter from home owner/tenant responsible
   - **I.** School ID (minors)
   - **J.** Check Stubs
   - **K.** Landlord Verification
   - **L.** Mail received with proof of address indicated

8. **Letter of Support**

   The letter must be written by the person providing room and board and/or assistance to pay for household bills and personal items. The letter must be signed, dated, and include a current phone number where we can contact the supporter.

Mission: The mission of Wellness Pointe is to provide access to high quality medical, dental, and social services across the patient lifecycle without regard to insurance status or ability to pay.

Rev. 04/07/16

Clear Form

WellnessPointe

1107 E. Marshall Ave.
Longview, TX 75601
(903)758-2610

ACCT # _____

Name: _____ DOB: _____

Effective: _____ Expires: _____

You have been qualified for the following programs that are marked below:

_____ ***TX-WHFPT -*** Covers Pap Smear, Birth Control, and female related issues. (Pills, Condoms, Depo-Provera shot, Liletta and Nexplanon). Covers STD check-up for men

_____ ***Family Planning -*** Covers Pap Smear, Birth Control, and female related issues. (Condoms, Pills, Depo-Provera shot, IUD's, Mirena, and Nexplanon). Covers STD check-up for males.

_____ ***Title V Obstetrics -*** Only covers maternity visits at the clinic.

_____ ***Title V Pediatrics -*** Covers well child checks and sick visits for kids that are not Medicaid eligible. **Recent Medicaid denial letter is required.**

_____ ***BCCP / MBCCS -*** Covers mammograms and pap smears. ***BCCP will only cover 1 pap smear every 3 years***, after that pap smears will be covered under a Sliding Fee Scale. Also covers: Colposcopy, Cryosurgery, & leep.

_____ ***Primary Health Care (PHC) -*** Covers most medical services.

Patient was screened for third-party insurance coverage.

_____ ***Sliding Fee Scale / SFS General Practice -*** Discount based on your income.
****Labs and prescriptions are separate.**** LABS ARE _____ Each

_____ ***GYN / Sterile SFS -*** This discount is based on your income.
****Labs and prescriptions are separate.****

_____ ***GYN / Non-Sterile SFS -*** This discount is based on your income.
****Labs and prescriptions are separate.****

_____ ***Dental - Limited -*** Exam and preventive services only.

_____ ***Dental SFS -*** Exam, X-Rays, preventive, restorative, oral surgery, and periodontal.

_____ ***Mental Health Counseling / Substance Abuse -*** ***Prescriptions are not included***

_____ ***Optometry -*** Eye Exam.

_____ ***Optical -*** New Globe Frames & Standard Lenses **ONLY.**

PATIENT / CHILD(REN) referred to MEDICAID / CHIP / COUNTY.
I acknowledge that I must report the following changes: income, family composition, residence, address, employment, types of medical insurance coverage, Medicaid and/or third-party coverage benefits **no later than 30 days after knowledge of the change.**

Signature: _____ ***Date:*** _____

Revised 11/21/19