NEW HORIZONS
HEALTHCARE

Solutions for a healthy community.

New Patient Packet

REV. 2026

Please **read** the entire packet, **complete** the applications, and **bring** all necessary documentation to your appointment with our Eligibility Coordinator.

Your appointment will be rescheduled with the Eligibility Coordinator if packet is incomplete or requested documentation is not available.

For any questions regarding the application please call: 540-362-0360

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Patient Information

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

Preferred Name: _____ Date of Birth: _____

Mailing Address City, ST, Zip: _____

County:_____ Do you need an interpreter? Yes/No Language: _____

Home Telephone Number: (___)_____-_____ Email address: _____

Cell Telephone Number: (___)_____-_____

Work Telephone Number: (___)_____-_____ How did you hear about us? _____

Emergency Contact

Name: _____ Relation:_____

Home Telephone Number: (_____)_____--_____ Cell Telephone Number: (____)_____-_____

Home Address:_____

Responsible Party

Name: _____ Telephone Number:(_____)_____--_____

Home Address:_____

Responsible Party Signature:_____

Notice of Privacy Practices

I hereby acknowledge that I have been given the opportunity to review and/or receive a copy of New Horizons Healthcare's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Director of Compliance and Risk Management. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.

Signature of Responsible Party _____ Date:_____

Services New Horizons Healthcare Offers

Check all services that are offered by New Horizons Healthcare that you are interested in
(See Orientation Booklet received at first appointment for a complete list of services)

- ❑ **Pharmacy – The New Horizons Healthcare Pharmacy is a full-service pharmacy that is open to the public. Provides reduced rates for patients, medication assistance program and free delivery within 15 miles.**
- ❑ **Medical – Adult including Open Access, women's health, sliding fee discount, sick & routine visits, annual physicals, immunizations, chronic disease management, lab & x-ray. Children's including well child/Adolescent care, preventive medicine, immunizations, well-baby care, school/sport physicals.**
- ❑ **Behavioral Health - Fully integrated with our medical and dental services. As an integrated services facility, patients requesting counseling services, psychiatric evaluation and treatment are required to first be established as a New Horizon's medical patient.**
- ❑ **Dental – Preventive Care including oral examinations, cleaning, fluoride and sealants, X-rays, fillings, root canals, crowns, bridges and dentures.**
- ❑ **OBAT Services- provides treatment for all types of Substance Use Disorders, including a combination of FDA-approved Medication-Assisted Treatment, behavioral health group and individual counseling, and care management services. There is no requirement to be an established patient for this service.**

Account # _____ Date of Birth _____

Please answer the following questions to the best of your ability. Data is collected for funding purposes only and all information will be kept confidential and anonymous. This allows us to continue to offer you the best level of care possible with discounted rates.

What is your race? – Please mark one.

- ○ African American
- ○ Asian
- ○ Asian Indian
- ○ Caucasian
- ○ Chinese
- ○ Filipino
- ○ Guamanian or Chamorro
- ○ Japanese
- ○ Korean
- ○ Native American
- ○ Native Hawaiian
- ○ Other Asian
- ○ Other Pacific Islander
- ○ Pacific Islander
- ○ Samoan
- ○ Vietnamese
- ○ More than one race
- ○ Prefer not to answer

What is your Ethnicity? (Region of origin considered for race category per Census Bureau): Mark all that apply.

❑ American Indian or Alaskan Native
- ○ North American
- ○ Central America
- ○ South America

❑ Asian
- ○ Far East
- ○ South East
- ○ Indian

❑ Black or African American
- ○ Africa

❑ Hispanic, Latina/o or Spanish
- ○ Mexican, Mexican American, Chicano/a
- ○ Puerto Rican
- ○ Cuban
- ○ Another Hispanic, Latino/a or Spanish Origin
- ○ Hispanic, Latino/a, Spanish Origin Combined

❑ Native Hawaiian or Other Pacific Islander
- ○ Hawaii/Guam
- ○ Pacific Islands
- ○ Samoa

❑ White
- ○ Europe
- ○ Middle East
- ○ North Africa

What is your preferred Language?
- ○ English
- ○ Other (please specify):_____

What is your sex assigned at birth? ○ Male ○ Female ○ Chose not to answer

Individual Annual Salary: _____ Family Income: _____ Family Size _____

What is your sexual Orientation? Please select or describe below.
- ○ Straight or Heterosexual
- ○ Lesbian/Gay or Homosexual
- ○ Bisexual
- ○ Do not Know
- ○ Choose not to disclose
- ○ Something else, please describe: _____

How do you identify your gender? Please select or describe below.
- ○ Male
- ○ Female
- ○ Transgender Male/ FTM
- ○ Transgender Female/MTF Genderqueer
- ○ Choose not to disclose
- ○ Additional Gender Category/Other please describe: _____

Are you any of the following? Please mark all that apply.
- ○ Veteran
- ○ Active Duty Military
- ○ Migrant worker
- ○ Agricultural Worker
- ○ Homeless

If you are homeless, where do you currently stay?
- ○ Doubling up - living with someone
- ○ Street
- ○ Other
- ○ Transitional
- ○ Unknown
- ○ Homeless Shelter
- ○ Permanent Supportive Housing

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Last Name:	First Name:	DOB:

INSURANCE DECLARATION PAGE

Please present ALL insurance cards to Eligibility Coordinator at time of appointment.

I currently do not have any medical insurance or pharmacy prescription coverage, whether through the government (Medicare or Medicaid), employment, or a private company. When I receive insurance coverage or pharmacy prescription coverage, I will notify New Horizons Healthcare within 30 days of the start date of the new insurance and will provide a copy of my card.

Initial here: ☐ *If no, skip to the pharmacy section*

PRIMARY INSURANCE COVERAGE

INSURANCE COMPANY INFORMATION	SUBSCRIBER INFORMATION
Company Name: _____	Policy Holder's Name: _____
Address: _____	Policy Holder's DOB: _____
City, St, Zip: _____	Policy Holder's Employer: _____
Subscriber/Policy/Medicaid/Medicare #: _____	Relationship to the Patient: _____
Group #: _____	

Does your **primary** insurance offer prescription drug coverage? Y / N

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY INFORMATION	SUBSCRIBER INFORMATION
Company Name: _____	Policy Holder's Name: _____
Address: _____	Policy Holder's DOB: _____
City, St, Zip: _____	Policy Holder's Employer: _____
Subscriber/Policy/Medicaid/Medicare #: _____	Relationship to the Patient: _____
Group #: _____	

Does your **secondary** insurance offer prescription drug coverage? Y / N

DENTAL INSURANCE COVERAGE

INSURANCE COMPANY INFORMATION	SUBSCRIBER INFORMATION
Company Name: _____	Policy Holder's Name: _____
Address: _____	Policy Holder's DOB: _____
City, St, Zip: _____	Policy Holder's Employer: _____
Subscriber/Policy/Medicaid/Medicare #: _____	Relationship to the Patient: _____
Group #: _____	

PREFERRED PHARMACY INFORMATION

New Horizons has an onsite pharmacy located both location that allows you to stop by after your appointment and have your prescription filled.

❑ New Horizons Melrose Pharmacy
3716 Melrose Ave, Roanoke, VA

❑ New Horizons Valley View Pharmacy
5060 Valley View Ave, Roanoke VA

❑ Other please provide:
Pharmacy Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____

Does any other agency/organization pay for your services? (Ex. Every Woman's Life, PACT through BRBH, DARS, VDH, etc.?
Yes / No If yes, which organization(s)? _____

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SLIDING FEE APPLICATION

Patient Name **Patient Date of Birth**

We encourage all patients to apply for Our Sliding Fee program which provides discounts on many services if you qualify. Qualifying for our Sliding Fee program is based on your household income and size. You are required to report any household income and size changes to us as this may impact the amount you are expected to pay. You will be asked to review and update your information annually. If it is determined that you are not eligible for the Sliding Fee program and you have incurred charges, then you will be expected to pay the balance due. We will assist you by arranging a payment plan if needed. You will be asked to pay a minimum fee for your first visit until the Sliding Fee eligibility process is complete. The remaining cost of the first and subsequent visits will be based on the outcome of the determination.

If you do not wish to apply for the Sliding Fee program, then please opt out by initialing here: ☐

Please provide government issued photo identification for identity verification.
Please check off all types of income* coming into your household and provide at least one form of proof from the options provided for each type of income.**
**Income includes all monies coming into the household that may potentially be used to support the care, feeding, and medical needs of the household.*
***Household is defined as applicant plus spouse or significant other and their legal dependents.*

Types of Household Income	Acceptable Proof of Household Income Documents
Employment ☐	**EMPLOYER** CURRENT PAYSTUBS OR LETTER FROM EMPLOYER* Current Paystubs – One (1) month's worth of current paystubs showing gross income. Letter from Employer – A signed letter on company letterhead from employer stating one (1) month gross salary that includes the employer's address & phone number. **Provide paystubs for the last/previous month of everyone 18 years of age and older drawing an income within the household.*
Self-Employment ☐	**FEDERAL INCOME TAX RETURN** IRS 1040 & SCHEDULE C IRS 1040 - www.irs.gov/pub/irs-pdf/f1040.pdf Schedule C - Profit or Loss from Business - www.irs.gov/pub/irs-pdf/f1040sc.pdf
Unemployment ☐	**VIRGINIA EMPLOYMENT COMMISSION (VEC)** VERIFICATION OF BENEFITS LETTER OR DENIAL OF BENEFITS LETTER Online – Sign into your customer self-service portal at VEC.Virginia.gov portal. Phone – Call the Customer Contact Center at 866-832-2363.
Unemployed and/or Homeless ☐	**SHELTER** HOUSING AND SUPPORT VERIFICATION FORM If you are unemployed and living in a shelter, then request a Housing and Support Verification Form from New Horizons Healthcare and have a shelter representative complete the appropriate section. **FAMILY OR FRIENDS** HOUSING AND SUPPORT VERIFICATION FORM If you are unemployed and living with family or friends, then request a Housing and Support Verification Form from New Horizons Healthcare and have the family member or friend who is providing your food & shelter complete the appropriate section. **NO SUPPORT** SELF-DECLARATION OF INCOME FORM If you are unemployed, homeless, and no one is providing you with food & shelter, then request and complete a Self-Declaration of Income Form from New Horizons Healthcare.

Worker's Compensation ☐	**VIRGINIA WORKERS' COMPENSATION COMMISSION (VWC)** AWARD LETTER (AWARD ORDER) Online – Use the WebFile portal at webfile.workcomp.virginia.gov/login to obtain the Award Letter. Call – Call the Customer Contact Center at 877-664-2566 to request an Award Letter.
Social Security ☐ Disability (SSDI) ☐ SSI ☐	**SOCIAL SECURITY ADMINSTRATION (SSA)** BENEFIT VERIFICATION LETTER (PROOF OF INCOME LETTER) Online – Sign into your personal My Social Security account at SSA.gov. Click on the "Your Benefit Verification Letter" link on your dashboard. Select the Adobe PDF link to download or print the letter. Phone – Call the SSA Automated Phone Assistance at 800-772-1213 (TTY 800-325-0778). When you hear "How can I help you today?" say "proof of income". A copy will be mailed to you within 10 business days.
SNAP ☐ TANF ☐	**DEPARTMENT OF SOCIAL SERVICES (DSS)** BENEFIT APPROVAL LETTER (NOTICE OF ACTION) Online – Sign into your personal Commonhelp.Virginia.gov account to download or print the letter. Phone – Call the Enterprise Customer Service Center 855-635-4370. Local DSS Office – Call or visit your local DSS office.
VA Pension ☐ VA Disability ☐	**VETERAN AFFAIRS (VA)** BENEFIT SUMMARY LETTER (VA AWARD LETTER) Online – Sign into your personal My VA account at VA.gov and download or print the letter. Phone – If you have trouble downloading a letter, call the MyVA411 main information line at 800-698-2411 (TTY 711).
Child Support ☐	**LEGAL DOCUMENTS** SEPARATION AGREEMENT, DIVORCE DECREE, OR COURT ORDER Please provide a copy of the Separation Agreement, Divorce Decree, or Court Order that describes the amount of child support paid per month. **DIVISION OF CHILD SUPPORT ENFORCEMENT (DCSE)** STATEMENT OF PAYMENTS Online – Go to mychildsupport.dss.virginia.gov to view and print a "Statement of Payments"
Alimony ☐	**LEGAL DOCUMENTS** SEPARATION AGREEMENT OR DIVORCE DECREE Please provide a copy of the Separation Agreement or Divorce Decree.
Pension or Retirement Benefits ☐	**SOCIAL SECURITY ADMINISTRATION (SSA)** BENEFIT VERIFICATION LETTER (PROOF OF INCOME LETTER) If your pension is integrated with Social Security, then follow the directions above under Social Security Administration (SSA) to obtain a Benefit Verification Letter. **PENSION BENEFIT GUARANTY CORPORATION (PBGC)** INCOME VERIFICATION LETTER If your pension was taken over by the federal government, then request an Income Verification Letter from PBGC. Online – Sign into the MyPBA System at PBGC.gov Phone – Call 800-400-7242 **OPM RETIREMENT OFFICE** YOUR FEDERAL RETIREMENT BENEFITS If you are a retired federal employee then contact the OPM Retirement Office. Phone – Call 888-767-6738 & request a new copy of "Your Federal Retirement Benefits" Email – retire@opm.gov & request a new copy of "Your Federal Retirement Benefits" **FORMER EMPLOYER/PLAN ADMINISTRATOR** ANNUAL BENEFIT STATEMENT Contact your former employer's HR department or the pension fund administrator to request an Annual Benefit Statement, which outlines your retirement benefits. **FORM 1099-R** FORM 1099-R This form is sent by the pension or retirement plan administrator each January, showing the gross benefit and taxes withheld for the previous year.
Trust Fund Allotments ☐	**LEGAL DOCUMENTS** TRUST AGREEMENT Please provide a copy of the Trust Agreement.

Rental Income ☐	**FEDERAL INCOME TAX RETURN** IRS 1040 & SCHEDULE E IRS 1040 - www.irs.gov/pub/irs-pdf/f1040.pdf Schedule E - Profit or Loss from Business - www.irs.gov/pub/irs-pdf/f1040se.pdf **LEGAL DOCUMENTS** LEASE AGREEMENTS Please provide a copy of the signed Lease Agreements.
Subsidized Housing ☐	**HOUSING AUTHORITY** HOUSING AND SUPPORT VERIFICATION FORM Request a Housing and Support Verification Form from New Horizons Healthcare and have a Housing Authority representative complete the appropriate section.
Other Income ☐	Please provide proof of any other income coming into the household (not listed above) that may potentially be used to support the care, feeding, and medical needs of the household.

HOUSEHOLD MEMBER INFORMATION

First Name	Last Name	Date of Birth	Relation to Applicant	Monthly Income	Employer Name (if applicable)	Full-Time Student
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No

Please provide a copy of custody papers for "other" dependents in your home.

DECLARATION

The information provided above is, to the best of my knowledge and belief, complete, accurate, and true. I authorize the release of all information which New Horizons Healthcare may need to determine whether I qualify for financial assistance through the Sliding Fee program.

Patient or Parent/Legal Guardian Signature **Date**

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Last Name:	First Name:	DOB:

HOUSING AND SUPPORT VERIFICATION FORM

To determine eligibility for discounted services, please complete **ONE** of the following that apply to your situation as of the date of this form. We appreciate your cooperation and wish to assure you that any information provided will be considered confidential.

PATIENT STATEMENT

Check All That Apply:

- ❑ Do you receive any form of public assistance for housing or living expenses?
- ❑ Do you have anyone to vouch for your living arrangements?
- ❑ Other - Explain: _____

_____**Initial Here**

ARE YOU HOMELESS OR LIVE IN A SAFETY SHELTER? *(RAM, TRUST, SALVATION ARMY, ETC.)*

If yes, please have a representative of the shelter fill out this section and sign. Thank you.

To New Horizons Healthcare:

_____ has been a resident at _____
(Applicant's Name) *(Facility Name)*

from_____ to _____. _____
(Beginning Date) *(End Date)* *(Phone Number for Verification)*

_____ _____ _____
(Signature) *(Title)* *(Date)*

DO YOU RECEIVE SUBSIDIZED HOUSING?

If yes, please have a representative of the Housing Authority fill out this section and sign. Thank you.

To New Horizons Healthcare:

_____ is a current resident at _____
(Applicant's Name) *(Address)*

All rental fees are subsidized by _____ _____
(Locality Name) *(Phone Number for Verification)*

_____ _____ _____
(Signature) *(Title)* *(Date)*

IS YOUR FOOD AND SHELTER PROVIDED BY FRIENDS/FAMILY OR MEMBER/ORGANIZATION?

If yes, please have this section filled out and signed by the person providing assistance. Thank you.

To New Horizons Healthcare:

I _____ am providing _____with food and shelter
(Print Name) *(Applicant's Name)*

This individual has no other means of support to the best of my knowledge. I am providing this support until _____.
(Date)

_____ _____
(Signature) *(Date)*

AUTHORIZED RELEASE OF INFORMATION

I authorize any above named organization or person to release information for verification of housing and support (living expenses) as requested.

_____ _____
PATIENT OR PARENT/LEGAL GUARDIAN SIGNATURE DATE