Getting Started on the MEMPHIS Plan (Employer/Participant Copy)

Hello MEMPHIS Plan Employers and Participants, please read the following information below and sign to acknowledge your understanding. Call or email immediately if you have any questions. Thank you.

1. **PLEASE be RESPECTFUL and COURTEOUS in all interactions with volunteers and staff providing MEMPHIS Plan services. PLEASE be PRESENT and ON TIME for all appointments**. The healthcare services you are receiving are donated by concerned, generous medical professionals and staff who volunteer their time to serve our community. ***Inappropriate, disruptive behavior or missed, late arrival for appointments can result in termination from the plan***.

2. The MEMPHIS Plan is **NOT INSURANCE.** It is a health care ministry of Church Health**, comprised of volunteer physicians and donated medical services**. All services must be donated before they can be offered through the MEMPHIS Plan. If we cannot get a service donated, we cannot offer that service. This requirement is part of the MEMPHIS Plan Act of 1991, set forth by the state of Tennessee, and we do not have the authority to change, add or get bills donated for services beyond what is currently donated.

3. I understand all enrollment requirements, benefits and limits (non-covered services). I have read the **Enrollment Information Brochure** and acknowledge the list of covered and non-covered services available.

4. I understand that charges may be incurred by the MEMPHIS Plan participant/patient if services are not completely donated by MEMPHIS Plan physician or facility.

5. **Participants will be assigned a primary care provider**. Because doctors donate their services and are limited in the number of participants they can serve, *participants cannot choose their doctor*. **Doctors' offices have different procedures for becoming an established patient within their offices.** *I understand it is my responsibility to identify and follow the procedure for becoming an established patient in my assigned primary care physician's office.*

6. **Participants are assigned and covered at only one hospital in Memphis**, either Methodist University or Baptist Memorial ONLY (listed on your MEMPHIS Plan ID card). ***(Methodist LeBonheur 16 years or younger only).***

7. ***Participants are responsible for knowing their assigned hospital and are responsible for 100% of the charges when admitted to any hospital other than assigned hospital.***

8. **Church Health urgent care clinic, counseling, dental and optometry services are NOT a part of the MEMPHIS Plan.** Participants can access these services through Church Health clinic, but they must verify their income and **pay separately for the services**.

9. Employee coverage ends when employment ends. **It is effective the last day of *the month the termination notice arrives in the MEMPHIS Plan office, not the termination date*. Terminations must be faxed or emailed.**

10. **It is the responsibility of the EMPLOYER to pay the invoice in full** and collect the employee portion of the monthly fees from the employee.

I have read and will follow the above information and instructions.

Participant Signature/Date (or Employee)	Employer/Participant Signature/Date	Company Name

4/13/26

ChurchHealth

MEMPHIS Plan Enrollment Application

PARTICIPANT Information ONLY

Employer/Self Employed/MP Direct: _____
(circle one)

Your Name: _____ Sex: Male _____ Female _____
First M.I. Last

SSN: _____ Birthdate: _____/_____/_____
Month Day Year

Home Address: _____ _____
Number, Street City

_____ Home Phone: (_____)_____
State, Zip

Cell Phone: (_____)_____ Email Address: _____

Do you have third party health insurance? Yes ____ No ____
Are you in treatment or have had treatment recommended by a doctor or dentist for any illness or dental condition? Yes _____ No _____
If yes, please explain _____
_____

Have you been diagnosed with any of the following conditions? Yes____ No _____
(check all that apply)☐ Multiple Sclerosis ☐ Systemic Lupus ☐ HIV?AIDS ☐ Hepatitis C
☐ ALS (Lou Gehrig's Disease) ☐ Cancer ☐other (please explain) _____
_____

What is your household annual income? _____
What is your household family size that is included on your tax return? _____

Participant Signature: _____ **Date:** _____

Please verify that the applicant meets the qualifications. Eligible applicants must:

- Work at least 20 hours per week
- Have income at or below 200% of the federal poverty level, based on income and family size (see chart below)

2026 Federal Poverty Level – Annual Income 200%	Household/Family Size
$31,920*	1
$43,280*	2
$54,640*	3
$66,000*	4

Employer/Self Employed/MP Direct Eligibility Verification
I certify that this participant is eligible for the MEMPHIS Plan, has had the benefits explained to him/her.

Employer/Contact Signature: _____ **Phone:** (_____)_____
Date: _____

Office Use Only:
Accepted by: _____ Date: _____
Location:_____ Effective Date of Coverage: _____