Patient Eligibility Form

(Revised 8/25/20)

NAME: _____
Last First M.I.

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE (H): _____**CALL/MESSAGE?** ☐ YES ☐ NO

MOBILE PHONE: _____ **TEXT?** ☐ YES ☐ NO

EMAIL: _____

PREFERRED CONTACT: ☐ HOME PHONE ☐ MOBILE PHONE ☐ EMAIL

EMERG. CONTACT: _____ **PHONE:**_____

DATE OF BIRTH (mo/day/year):

SOCIAL SECURITY #:

SEX: ☐ FEMALE ☐ MALE

ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC

LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

Are you employed? ☐ **YES** ☐ **NO**

If YES, Where? _____

☐ Full-time ☐ Part-time ☐ Seasonal

Self-Employed? ☐ **YES** ☐ **NO**

Unemployed? ☐ **YES** ☐ **NO**

If YES, Why?

☐ Disabled ☐ Retired ☐ Homemaker
☐ Due to health ☐ Unable to find work

Race:
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Other: _____

Marital Status:
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Cohabitate

Medical Insurance Status:
- ☐ APPLIED for Medicaid
- ☐ Medicaid
- ☐ VA Benefits
- ☐ Medicare
- ☐ Private Insurance
- ☐ NONE

If Homeless,
- ☐ Shelter
- ☐ Street
- ☐ Live w/ others

Active Workman's Compensation?

☐ YES ☐ NO

Drug Allergies: ☐ YES ☐ NO

If YES, List:

If you receive Social Security Benefits:

☐ SSI ☐ RETIREMENT ☐ DISABILITY

IMPORTANT: Proof of household income may be requested more than once per year.

Do you receive SNAP (food stamp) benefits? ☐ YES ☐ NO If yes, how much? $_____

# of People in the Household: _____

Name of Household Member	Age	Relationship to Patient	Income Source (Job, SS, etc.)	Gross Monthly Amount
Patient:		SELF		$
				$
				$
				$
				$
			Total:	$

PATIENT AGREEMENT/DISCLOSURE:

Being truthful and of sound mind I attest I do / do not have prescription drug coverage. I agree to allow the —— Clinic and Commonshare to complete any patient assistance enrollment process on my behalf, which may include disclosure of personal and medical information. I also authorize the —- Clinic and Commonshare to share medical and financial information with any and all pharmaceutical providers for eligibility and audit purposes. I will immediately notify the — Clinic and Commonshare of any changes to my income, household size, or insurance status.

Signature: _____

Date: _____

For Staff Use ONLY:

	Date	Initials
Application :		
Consent Form:		
Photo ID		
Social Security Card:		
IRS Form:		
POI:		
Letter of Support:		

Percent Below FPL:
- ◊ Below 200%
- ◊ 200% - 300%
- ◊ 300%-400%
- ◊ Above 400%

Expires: _____

Issued by: _____

Date: _____

☐ **NOT ELIGIBLE:**

_____

Patient ID: