Patient Eligibility Screening

Patient Name: _____ **Today's Date**: _____

Date of Birth: _____ **Age 18-64**:_____ **Social Security #**_____

Physical Address (No P.O. Box):_____

City_____ **State**_____ **Zip**_____ **County**_____

Kendall County Resident? Yes ☐ No ☐ **Area**: Boerne ☐ Comfort ☐

Home Phone_____ **Cell Phone**_____ **Work Phone**_____

Language Spoken: English ☐ Spanish ☐ Other ☐

Have you ever received services at HCMfH? Yes ☐ No ☐ If so, when?_____

Male ☐ Female ☐ Females: **Are you pregnant?** Yes ☐ No ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Race: African American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐

Native American ☐ Pacific Islander ☐ Other_____

Do you currently have Health Insurance? Yes ☐ No ☐

If so, what type: Medicaid ☐ Medicare ☐ Affordable Care Act ☐ VA Health Benefits ☐
Workers Compensation Benefits ☐ Other ☐ - Please explain:_____

Are you currently employed? Yes ☐ No ☐ Name of Employer:_____

Are you a Veteran? Yes ☐ No ☐

Do you have photo ID? Yes ☐ No ☐ (Must bring to first visit. A copy will be retained in confidential patient chart)

Emergency Contact: _____ **Telephone Number:** _____

Members of Household, including self:

Name (The first person on list is yourself)	Relationship (Spouse/Child)	Social Security #	Sex M/F	Date of Birth (MO/Day/YR)	Work (Yes/No)	Income

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Are medical services needed now?_____

Name of practice where previous medical care was received:_____

How did you hear about this clinic?_____

Church Affiliation?_____

Is any member of your family ***RECEIVING*** any of the following?

☐ Yes	☐ No	Medicaid	☐ Yes	☐ No	TANF
☐ Yes	☐ No	CHIP	☐ Yes	☐ No	Food Stamps
☐ Yes	☐ No	Medical Insurance	☐ Yes	☐ No	Workman's Compensation
☐ Yes	☐ No	Dental Insurance	☐ Yes	☐ No	Alimony
☐ Yes	☐ No	VA Medical	☐ Yes	☐ No	Pension Benefits
☐ Yes	☐ No	Unemployment Benefits	☐ Yes	☐ No	SSI – Supplemental Security Income
☐ Yes	☐ No	Social Security Income	☐ Yes	☐ No	Child Support

I certify that the information I have given is up-to-date and correct. I understand that any falsification, misrepresentation, or withholding of information will result in the loss of eligibility to receive clinic services.

Printed name:_____Signature:_____Date:_____

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BELOW SECTION TO BE COMPLETED BY INTERVIEWER

New Applicant ☐ Renewal Applicant ☐

Total (Household) Income for all adults? Monthly:_____ Annually:_____

Income Verification Includes: previous year's income tax return, unemployment benefits, child support, disability check, retirement check, three months of paycheck stubs, food stamp verification, rental income, and all other proof of income. **Proof of income will be verified prior to patient seeing provider.**

Photo ID Includes: driver's license, passport, visa, immigration documents, student or work, photo ID from other country, or other form of photo identification. **Valid Photo ID will be verified prior to patient seeing provider.**

Type of Photo ID attained:_____Type of Income Verification attained: _____

Printed name of Interviewer:_____Date:_____