SAN JOSÉ CLINIC Eligibility Application

Application Date: _____

Applicant Information

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

Gender: ☐Male ☐Female **Have you received services at San José Clinic before?** ☐Yes ☐No

Street Address: _____

City: _____ **State:** _____ **ZIP:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐In Domestic Partnership

Race: ☐Hispanic ☐Not Hispanic ☐Unknown / Prefer Not to Answer

Ethnicity: ☐White ☐Black ☐Asian ☐Pacific Islander ☐Alaskan Native ☐American Indian ☐Prefer Not to Answer ☐Unknown

Preferred Method of Communication: ☐Mail ☐Phone ☐Email ☐MyChart ☐Do not contact ☐No preference

Veteran Status: ☐Yes ☐No

Members of Your Household, Including Yourself

	Name *(the first person on the list is yourself)*	Relationship *(spouse, child)*	Social Security #	Sex	Date of Birth *(MO/DAY/YR)*	Birthplace*	Work
1		SELF		☐M ☐F			☐Y ☐N
2				☐M ☐F			☐Y ☐N
3				☐M ☐F			☐Y ☐N
4				☐M ☐F			☐Y ☐N
5				☐M ☐F			☐Y ☐N
6				☐M ☐F			☐Y ☐N
7				☐M ☐F			☐Y ☐N

Is any member of your family receiving any of the following? ***Please indicate yes or no for <u>each item</u>***

Medicaid: ☐Yes ☐No
CHIP: ☐Yes ☐No
Medicare: ☐Yes ☐No
Medical Insurance: ☐Yes ☐No
Dental Insurance: ☐Yes ☐No
VA Medical: ☐Yes ☐No

Pension Benefits: ☐Yes ☐No
SSI – Supplemental Security Income: ☐Yes ☐No
Social Security Income: ☐Yes ☐No
Workman's Compensation: ☐Yes ☐No
Gold Card Harris County: ☐Yes ☐No
Unemployment Benefits: ☐Yes ☐No

Alimony: ☐Yes ☐No
Child Support: ☐Yes ☐No
Food Stamps: ☐Yes ☐No
TANF: ☐Yes ☐No

Disclaimer and Signature

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.

Signature: _____ **Date:** _____

Employee Section Only

□ New Applicant: _____ □ Application Renewal: _____

**Referral Source: _____

Has the person been affected by Hurricane Harvey? □ Yes*** □ No

***If yes, how? _____

My Chart? □ Yes □ No □ Declined

Husband ID: _____ Wife ID: _____

Husband Address: _____

Wife Address: _____

Income: _____

_____

_____

Indicate if child has Medicaid, CHIP, and if Birth Certificate was presented:

	Child's Name	Medicaid	CHIP	Birth Certificate
1		□ Y □ N	□ Y □ N	□ Y □ N
2		□ Y □ N	□ Y □ N	□ Y □ N
3		□ Y □ N	□ Y □ N	□ Y □ N
4		□ Y □ N	□ Y □ N	□ Y □ N

Eligibility Application

Interviewed by: _____ Start date: _____ Expiration date: _____

Annual Income: _____ Monthly Income: _____ Sliding Scale Classification: _____

APPLICATION NOTES: _____

_____

_____