|  |  |
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| San José Clinic- Fort Bend | Eligibility Application  Fecha:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## INFORMACION DEL APLICANTE

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Apellido**: **Primer Nombre: Medio Nombre:** | | | | | | |
| **Sexo**  Femenino Masculino | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **¿Ha recibido servicios en la Clinica San José anteriormente?** 🞎 Si 🞎 No | YES | NO | Have you received services at San Jose? | YES | NO | | | | | |
| **Direccion: Ciudad: Estado: Codigo:** | | | | | | |
| **Telefono:** | **Celular:** | | | **Correo Electronico:** | | |
| **Estado Civil:**  ­­Soltero(a) Casado(a) Divorciado(a)  Separado(a Viudo(a) Union Libre | | | **Raza:**  Blanco Afro Americano Asian  Indio Amer.  Nativo de Alaska Nativo de Hawaii No se | | | **Etnia:**  Hispano  No Hispano  No se |
| **Modo Preferido de ser contactado:**  No preferencia Ninguno Correo Telefono Correo Electronico Athena Portal | | | | | **Veterano:**  No Si | |

## MIEMBROS DE SU HOGAR, INCLUYENDO USTED:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Nombre**  **(la primera persona es Ud mismo(a)** | **Parentesco**  **(pareja, hijo(a))** | **# DE SEGURO SOCIAL** | **Sexo**  **M/F** | **Fecha de Nacimiento**  **(MO/DAY/YR)** | **\*Lugar de Nacimiento** | **¿Trabaja?**  **SI/NO** |
| **1** |  | **YO MISMO(A** |  |  |  |  |  |
| **2** |  |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |  |

## ¿ESTA RECIBIENDO ALGUN MIEMBRO DE SU FAMILIA CUALQUIERA DE LOS SIGUIENTES?

***Por favor indique SI o NO para cada uno:***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Si  🞎 | | No  🞎 | Medicaid | | Si  🞎 | No  🞎 | | Beneficios de Pension | |
| Si  🞎 | | No  🞎 | CHIP | | Si  🞎 | No  🞎 | | SSI – Ingreso Suplementario de Seguro | |
| Si  🞎 | | No  🞎 | Medicare | | Si  🞎 | No  🞎 | | TANF | |
| Si  🞎 | | No  🞎 | Seguro Medico | | Si  🞎 | No  🞎 | | Cumplimiento de Mantenimiento de Niños | |
| Si  🞎 | | No  🞎 | Seguro Dental | | Si  🞎 | No  🞎 | | Estampillas de Cominda | |
| Si  🞎 | | No  🞎 | Ayuda de Veteranos | | Si  🞎 | No  🞎 | | Tarjeta Dorada | |
| Si  🞎 | | No  🞎 | Beneficios de Desempleo | | Si  🞎 | No  🞎 | | Compensacion de trabajo | |
| Si  🞎 | | No  🞎 | Seguro Social (ingreso) | | Si  🞎 | No  🞎 | | Derecho Pension | |
|  | | |  | | |  | |  | |
| **RENUNCIA Y FIRMA** | | | | | | | | | |

***Yo certifico que la información que he dado esta al día y correcta. Yo entiendo que con cualquier falsificación o el no dar la información complete se pierde la elegibilidad para recibir los servicios ofrecidos en la clinica.***

|  |  |  |  |
| --- | --- | --- | --- |
| Firma: |  | Fecha: |  |

## EMPLOYEE SECTION ONLY

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| --- |
| 🞏 **New Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 🞎 **Application Renewal**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\*\*Referral Source:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Was the person affected by Harvey? \_\_\_\_\_Yes\*\*\* \_\_\_\_\_No**

**\*\*\*If yes, How?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Athena Portal? Yes  No  Refused**

**ID: (Husb) (Wife)**

**Address: (Husb) (Wife)**

**Income:**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **CHILDS NAME** | **MEDICAID** | **CHIP** | **BIRTH CERTIFICATE** |
|  |  |  |  |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Eligibility application:**   |  |  |  | | --- | --- | --- | | **Interviewed by:** | **Start date:** | **Expiration date:** | |  |  |  | | **Annual Income:** | **Monthly Income:** | **Sliding Scale Classification:** | |  |  |  | |  |
|  |  |
| **APPLICATION NOTES:** |  |

**501 (C) 3 Nonprofit Organization A Ministry of the Archdiocese of Galveston-Houston A United Way Agency**