|  |  |
| --- | --- |
| 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

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

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

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

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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**