



Community Clinic

2300 Kurt Street, Eustis, FL 32726 Phone: (352)589-2501 Fax: (352)589-4041

Application to Determine Eligibility
For Medical Care

_____ NEW PATIENT _____ ANNUAL REENROLLMENT _____ RETURNING PATIENT

CURRENT MEDICAL CONCERN: _____

APPLICANT'S NAME _____

(OTHER NAMES KNOWN BY) _____

APPLICANT'S PHYSICAL ADDRESS _____

MAILING ADDRESS IF DIFFERENT _____

IS YOUR PRIMARY RESIDENCE PHYSICALLY LOCATED IN LAKE COUNTY? Y N

How long have you been a Lake County resident? _____

Do You Own ent Your H ?

TELEPHONE NUMBER (DAY) _____ (EVENING) _____

APPLICANT IS SINGLE MARRIED DIVORCED WIDOWED SEPARATED

IF DIVORCED OR SEPARATED, ARE YOU RECEIVING ALIMONY/SPOUSAL SUPPORT? Y N

IF YES, HOW MUCH PER MONTH? _____

ARE YOU A CITIZEN OF THE UNITED STATES? Y N

HAVE YOU SERVED IN THE MILITARY? Y N

ARE YOU RECEIVING MEDICAID or MEDICARE? Y N MEDICAID/MEDICARE # _____

ARE YOU OR YOUR SPOUSE RECEIVING SOCIAL SECURITY? Y N

DO YOU HAVE **ANY FORM** OF HEALTH INSURANCE? Y N WITH WHOM? _____

DOES YOUR SPOUSE HAVE HEALTH INSURANCE? Y N

ARE YOU ENROLLED IN MEDICALLY NEEDY SHARE OF COST PROGRAM? Y N DON'T KNOW

List all who live in the same house with you. Use another sheet if necessary.

NAME	DATE OF BIRTH	Relation to Applicant	Status: Working/Student

ARE YOU EMPLOYED? Y N Full Time Part Time Self Employed Seasonal
IS YOUR SPOUSE EMPLOYED Y N Full Time Part Time Self Employed Seasonal

If Yes: for whom? _____ how long? _____
Spouse: for whom? _____ how long? _____

If No: How long have you been out of work? _____

Are you receiving unemployment benefits? Y N

Are you looking for work? Y N

IS YOUR UNEMPLOYMENT DUE TO AN ACCIDENT OR INJURY? Y N

If yes, are you receiving Workman's Comp.? Y N

How long ago was your injury? _____

IS YOUR UNEMPLOYMENT DUE TO AN AUTOMOBILE ACCIDENT? Y N

IS THERE ANY LAWSUIT OR ATTORNEY INVOLVED? Y N

Briefly describe the result of the accident or injury:

DO YOU OR YOUR SPOUSE HAVE A CHECKING OR SAVINGS ACCOUNT? Y N

ARE YOU OR YOUR SPOUSE RECEIVING FINANCIAL OR MATERIAL ASSISTANCE FROM ANY PERSON OR AGENCY?
Y N (Including food stamps)

Please provide information regarding assistance below:

NAME	RELATIONSHIP	AMOUNT PER MONTH

THE FOLLOWING PAGE EXPLAINS THE DOCUMENTATION THAT MUST ACCOMPANY THIS APPLICATION. PLEASE BE SURE ALL PAPERWORK IS INCLUDED. FAILURE TO RETURN ALL NECESSARY INFORMATION COULD RESULT IN A DELAY.

PLEASE SUBMIT COPIES OF THE REQUESTED INFORMATION:

Proof of Residency: Any 1 of the following within 12 months. Must be for same address.

- Property Tax Bill
- Lease, housing, rent/mortgage agreements/receipts
- Utility bills for current address for applicant
- Form from an approved social service agency
- Enrollment in a facility or agency program, such as HUD
- Notarized verification letter of support
- Vehicle Registration in the name of applicant/spouse/guarantor
- Official mail received by applicant at NLCHD address
- Declaration of Domicile

Identification: Any 2 of the following. 1 must be a photo ID

- Birth Certificate
- Drivers License/Identification card – with correct address
- Social Security Card
- Official document that includes name, address, social security number, IRS 4506T form
- Alien Registration receipt card (Green Card, Form I-151 or I551)
- Any government issued photo identification

Income: (Provide all that apply for family Unit; to include spouse or partner)

- Pay Stubs – Previous 3 months or most recent if Year to date is indicated.
- Most recent tax return, 1040(including supporting schedules) or IRS 4506T form
- Bank Statements – Previous 3 months for all accounts
- Unemployment/Workers Comp Statement
- Child Support/Alimony
- Social Security Benefits for any family member
- Pensions/Retirements/Interest
- Veterans Benefits
- Any settlements, court-ordered or otherwise
- If Self Employed: Previous Year’s Business Tax Return
- If zero income/homeless:
 - Letter of Hardship from the patient indicating \$ amount of assistance (notarized)
 - Letter of Assistance indicating dollar amount of contributions per month from supporting family or friends. (notarized)

Assets: (Provide all that apply) _____ a signed affidavit indicating any of the following owned assets and their value:

- Checking and Saving account
 - The equity value of real property other than the homestead.
 - The case surrender value of life insurance, if the combined face value of all policies owned by the family unit exceeds \$1500
- Motor vehicles and additional automobiles, excluding one primary vehicle
- Recreational vehicles
- Trusts
- Stocks, bonds, Checking, Savings accounts, IRAs, CDs or any other financial asset statements for past 3 months

-Medicaid Denial Letter dated within 1 year. Apply online at www.myflorida.com/accessflorida/ or call 1-866-762-2237. **(NEEDED FROM ALL APPLICANTS)**

-If you have served in the military. **Provide a copy of your DD214/Letter from VA indicating ineligible for services.**

When you have collected ALL the above information that relates to you, please return it to Community Primary Health Clinic as soon as possible.

By signing below you are aware that Community Primary Health Clinic reserves the right to make credit inquiries and may run your credit report.

Printed Name:_____ DOB: _____ SS# _____

Signature:_____ Today’s Date: _____