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: _______________