PATIENT ELIGIBILITY APPLICATION

Ann Silverman Community Health Clinic •595 West State Street • Doylestown, Pennsylvania 18901
Phone: 215-345-2260 • Fax: 215-489-7236

Name of Applicant: _____ Date of Birth: ____/____/____
(Last names) (First Name) (Middle initial) month/day/year

Phone Number: _____Application Date: ____/____/____

The Ann Silverman Community Health Clinic provides free medical care, dental care and behavioral health services for uninsured people who live in Bucks County and have a limited income.

Please follow the instructions and complete page 2.

- Provide the names and income for each individual that lives in your household, whether or not they are related to you, and indicate if they are also applying for clinic services.

- Provide the following for all persons who are applying to the clinic for services:
  - **Proof of Identity.** Acceptable proof includes:
    - Any government issued photo ID
    - Driver's license, passport, or permanent resident alien card.
    - Birth certificates must be used for individuals that do not have a photo ID
  - **Proof of Residency**. Acceptable proof includes:
    - Telephone or utility bill
    - Tax bill or lease with your name and current address
    - Ordinary mail or bank statements are not acceptable

- Provide the following for all persons who live in your household.
  - **Proof of income includes**:
    - the last three (3) pay stubs or a letter from employer(s)
    - if self-employed, profit and loss statement for each of the last three (3) months
    - proof of child support or alimony or court orders for child support
    - Letter from unemployment, worker's compensation, SSD, SSI, etc.
    - letter(s) of support from family or friends that are assisting individuals in the household
  - **Most recent Federal** (Not State) **Income Tax returns and W2.**
  - **Recent Bank Statement(s) for Savings and/or Checking Accounts.**

Missing information will result in a delay in your approval for clinic services.

Eligibility is re-evaluated every 12 months.

OFFICE USE ONLY

Date of review: By:	Date of determination: By:
☐ APPROVED Medical/Social Services Only -	
☐ APPROVED All Clinic Services -	
# Adults ___ # Children ___ Children Insured? Y N Income:$ ___ /month Source: ___	
☐ INELIGIBLE Reason:	Available Funds: ___

HOUSEHOLD FINANCIAL ASSESSMENT

I. **List your** name and every person who lives in your house/apartment, including family, friends, and roommates.

☑	Name	Age	Date of Birth	Insurance (if insured)
☐				
☐				
☐				
☐				
☐				
☐				

II. **INCOME - Names of every person in the household who works and their weekly BEFORE TAX wages. You must provide proof of all income in the household.**

Name	Place of Employment	# Hours worked in a week	Hourly wage	

- **Do you, or does anyone in your household, receive child support?** Yes _____ No _____
  List the amount received for each child.

Amount per week	For (child's name)

- **Do you, or does anyone in your household, receive a pension, Social Security, Workmen's Compensation, Unemployment, alimony or any other source of income?** Yes ____ No____
  List who receives it, how much, and how often it is received (for example $/wk, $/month.)

Name	Pension	Social Security	Workmen's Compensation	Unemployment	Alimony	Other

- **RESOURCES - Do you, or does anyone in your household, have a checking account or savings account?** Yes __ No __ If Yes, you must provide a recent statement for each account.

Owner	Type	Value

- **Amount of rent or mortgage paid monthly** _____
  Do you share expenses with anyone? ___Yes ___ No List name _____
  What expenses are shared? (Rent, utilities) _____
  Have you applied for insurance through the Affordable Care Act? ___Yes ___ No
  Results_____

PLEASE READ AND SIGN

1. I have provided true information about every person who lives in my household.
2. I understand that failure to provide true information may result in terminating me from the Clinic including medical & dental care and medications.
3. **I agree to tell the clinic about any insurance and income changes for me and my family.**

_____ _____

YOUR SIGNATURE **DATE SIGNED**

Ann Silverman Community Health Clinic

Please Print

TODAY'S DATE: _____/_____/_____

PATIENT'S NAME: _____ AGE: _____

BIRTHDATE: Month_____ Day_____ Year_____ SEX: _____ RACE: _____

PATIENT'S SOCIAL SECURITY #: _____ LANGUAGE: English Spanish Other: _____

HOME PHONE: _____ CELL #: _____ WORK #: _____

EMAIL ADDRESS: _____

STREET ADDRESS: _____ APT. # _____

CITY: _____ STATE: _____ ZIP: _____

Mailing Address or PO Box if different than street address: _____ APT. # _____

CITY: _____ STATE: _____ ZIP: _____

If Patient is a Minor: *PARENT*/GUARDIAN NAME: _____

PARENT/GUARDIAN BIRTHDATE: ____/____/_____ PARENT/GUARDIAN SOCIAL SECURITY #: _____

PARENT/GUARDIAN ADDRESS (if different than above): _____

CITY: _____ STATE: _____ ZIP: _____

Emergency Contact Information

NAME: _____ RELATIONSHIP TO YOU: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ BIRTHDATE: _____/_____/_____

If we cannot reach you, do we have permission to talk to this person regarding your personal health information?

Yes _____ No _____

Please Answer All of the Following:

1. Do we have permission to leave a message on your voicemail or answering machine regarding your personal health information? Yes _____ No _____
2. Do you have any medical or dental insurance? Yes _____ No _____

   If yes, what is the name of the insurance company: _____
3. Are you a Veteran? Yes _____ No _____
4. Is this visit in any way related to an accident of any kind or an injury on the job? Yes ___ No ___

   If yes, describe the accident or injury? _____
5. What pharmacy do you prefer? Name: _____

   Address: _____ City _____ State: _____

   Phone: _____ Fax: _____