San José Clinic Eligibility Application

Application date:_____

APPLICANT INFORMATION

Last Name:	**First Name:**	**Middle Name:**
Gender ☐ Female ☐ Male	Have you received services at San Jose? ☐Yes ☐No	
Street Address:	**City:**	**State:** **Zip Code:**
Home Phone:	**Cell Phone:**	**Email Address:**

Marital Status:
☐Single ☐Married ☐Divorced
☐Separated ☐Widow ☐Domestic Partner

Race:
☐White ☐Black ☐Asian ☐American Indian
☐Pacific Islander ☐Alaskan Native
☐Refuse ☐Unknown

Ethnicity:
☐Hispanic
☐Not Hispanic
☐Unknown/Refuse

Would you like to enroll in the patient portal?
☐No ☐Yes

Were you affected by Hurricane Harvey? If so, how?
☐No ☐Yes

Preferred method of contact:
☐No preference ☐Do not contact ☐Mail ☐Phone ☐Email ☐Portal

Veteran Status:
☐No ☐Yes

MEMBERS OF YOUR HOUSEHOLD, INCLUDING SELF

	Name (the first person on the list is yourself)	Relationship (spouse, child)	Social Security #	Sex M/F	Date of Birth (MO/DAY/YR)	*Place of Birth	Work YES/NO
1		SELF					
2							
3							
4							
5							
6							
7							

IS ANY MEMBER OF YOUR FAMILY RECEIVING ANY OF THE FOLLOWING?

Please indicate Yes or No for <u>each</u> item:

Yes	No		Yes	No	
☐	☐	Medicaid	☐	☐	Pension Benefits
☐	☐	CHIP	☐	☐	SSI – Supplemental Security Income
☐	☐	Medicare	☐	☐	TANF
☐	☐	Medical Insurance	☐	☐	Child Support
☐	☐	Dental Insurance	☐	☐	Food Stamps
☐	☐	VA Medical	☐	☐	Gold Card Harris County
☐	☐	Unemployment Benefits	☐	☐	Workman's Compensation
☐	☐	Social Security Income	☐	☐	Alimony

DISCLAIMER AND SIGNATURE

I certify that the information I have given is up-to-date and correct. I understand that any falsification, misrepresentation, or withholding of information will result in the loss of eligibility to receive clinic services. If my financial or insurance situation changes, my eligibility status will need to be re-evaluated. I give permission to share this information with auditors or pharmaceutical companies as required.

Signature: _____ Date:_____

Eligibility

To receive services at San José Clinic, low-income, uninsured individuals and families must first complete an eligibility interview. Medicaid, Medicare, Affordable Care Act plans are also considered different types of health insurance coverage. Those that qualify for services will receive a patient account, providing them access to services.

1. Photo Identification

Please bring one of the following for each adult:

- State Driver's License or Identification Card (current or expired)
- Passport or Visa
- U.S. Immigration documents
- Student or work ID*
- Photo ID from another country
- Other forms of photo identification*
- *If a non-government issued ID is provided, another form of ID will need to be provided (such as birth certificate, marriage license, social security card, etc.)
- Please bring all of the following for each child:
- Birth Certificate or Birth Fact Record
- Medicaid or CHIP ID cards

2. Proof of Household Income

Please bring all documents that you have.

- One month's worth of recent pay stubs
- If you do not receive paystubs, a completed wage verification letter from employer will be accepted.
- Most recent tax return
- Letter of support
- Welfare benefit documents (TANF and Food Stamps)
- SSI or Social Security certification documents
- Unemployment documents / Worker's compensation
- Child support documents

3. Proof of Address

- Any piece of mail that is delivered through the Postal Service with the patient's name and address.

Please feel free to call 713-490-2610 if you have any questions.
Fax (713) 490-2644
Email – sjcmteligibility@sanjoseclinic.org