Living Water Community Clinic Eligibility Form

Name: Last Name_____ First Name_____ MI ___

Social Security Number_____- _____- _____ **Date of Birth** _____-_____-_____
Month Day Year

Street Address (Physical/Mailing) _____ PO Box: _____

City_____ State VA Zip _____

Phone # Home (_____) _____ Cell (____) _____ Work (_____) _____

Emergency Contact Person _____ Relationship _____

Contact Person Pho # (_____) _____ Home Work or Cell _____

Race: Caucasian* African-American* Hispanic* Other _____ **Gender:** Male Female

Marital Status: Married, Single, Widowed, Divorced, Separated **Do you have any Ins?** No__ Yes___
Household Size: # Adults: _____ # of Dependents (claimed on taxes) ____
Do You Work?_____ Where?_____

For the Medication Asst. Program, we need to know if you filed taxes last yr? Yes ___No__

Total Net Household Income: Monthly

	Patient	Spouse	Father	Mother	Other
SALARY/WAGES					
SOCIAL SECURITY					
SOC SEC DISABILITY					
PENSION					
UNEMPLOYMENT					
WORKMAN'S COMP					
VETERAN'S BENEFITS					
FOOD STAMPS-SNAP					
CHILD SUPPORT					
TOTAL					
TOTAL ALL COLUMNS:	$	$	$	$	$

	Need:	**Received**		**Need:**	**Received:**
Residency Proof			Notarized Letter of Support		
1040 IRS Tax Copy (if filed)			Medicaid Denial Letter		
Pay Stubs (last 30 days)			4506 T (non-filing taxes)		
Soc Sec Benefit Letter			Veteran's Benefit Letter		
Food Stamp Letter			Unemployment Benefit Letter		
Wage & Earning Statement			Verification of Employment		

Do you currently take Brand Name Medications?: (may give MAP app). **Yes** _____ **No** _____
Are you presently enrolled in the Medication Assistance Program? Yes ____ **No**_____

How did you hear about the Living Water Community Clinic? _____

ELIGIBILITY PERIOD:
1 MONTH (needs to provide more information) ___/___/___to ___/___/___
6 MONTH (financial information provided) ___/___/___ to __ /___/____ ___/___/___ to __ /___/____

Patient Signature:_____ Screener's Sig: _____
Date: _____ _____ _____ **NEW or RENEWAL**