TOMAGWA
HealthCare Ministries

Eligibility Application

Applicant Information

Date of Birth: _____

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Gender: ☐Male ☐Female **Have you received services at TOMAGWA before?** ☐Yes ☐No

Street Address: _____

City: _____ **State:** _____ **ZIP:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐In Domestic Partnership

Ethnicity: ☐Hispanic ☐Not Hispanic ☐Unknown / Prefer Not to Answer

Race: ☐White ☐Black ☐Asian ☐Pacific Islander ☐Alaskan Native ☐American Indian ☐Prefer Not to Answer ☐Unknown

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

Veteran Status: ☐Yes ☐No **Language:** ☐English ☐Spanish ☐Other

Members of Your Household, Including Yourself

	Name (the first person on the list is yourself)	**Relationship** (spouse, child etc)	**Social Security #**	**Sex**	**Date of Birth** (mo/day/yr)	**Age**	**Work**
1		SELF		☐M ☐F			☐Y ☐N
2				☐M ☐F			☐Y ☐N
3				☐M ☐F			☐Y ☐N
4				☐M ☐F			☐Y ☐N
5				☐M ☐F			☐Y ☐N
6				☐M ☐F			☐Y ☐N
7				☐M ☐F			☐Y ☐N

Is any member of your family receiving any of the following? ***Please indicate yes or no for <u>each item</u>***

Medicaid: ☐Yes ☐No
CHIP: ☐Yes ☐No
Medicare: ☐Yes ☐No
Medical Insurance: ☐Yes ☐No
Dental Insurance: ☐Yes ☐No
VA Medical: ☐Yes ☐No

Pension Benefits: ☐Yes ☐No
SSI – Supplemental Security Income: ☐Yes ☐No
Social Security Income: ☐Yes ☐No
Workman's Compensation: ☐Yes ☐No
County Assistance: ☐Yes ☐No
Unemployment Benefits: ☐Yes ☐No

Alimony: ☐Yes ☐No
Child Support: ☐Yes ☐No
Food Stamps: ☐Yes ☐No
TANF: ☐Yes ☐No

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.

Signature: _____ **Date:** _____