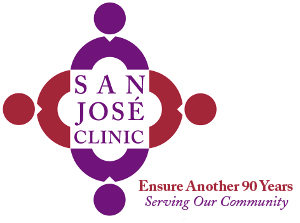
**San José Clinic – Eligibility Application**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Harris County Resident:** 🞏 **Yes**🞏 **No Current Gold Card Holder:** 🞏 **Yes**🞏 **No** | | | |
| **Have you ever received services at San Jose Clinic?** 🞏 **Yes** 🞏 **No Child/Sibling on Medicaid:** 🞏 **Yes** 🞏 **No** | | | |
| **Have you ever brought one of your children to the clinic to be vaccinated or for any other reason?** 🞏 **Yes** 🞏 **No** | | | |
| **Name of Applicant (adult) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Marital Status:** 🞎 **Single** 🞎 **Married** 🞎 **Common Law** 🞎 **Divorced** 🞎 **Widow(er)** 🞎 **Separated** | | | |
| **Physical Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **Apt. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **State: \_\_\_\_\_\_** | **County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Race: \_\_\_ American Indian/Alaska native; \_\_\_ Asian; \_\_\_ African American; \_\_\_ White; \_\_\_ Native Hawaiian**  **Ethnicity: \_\_\_ Hispanic or Latino; \_\_\_ Not Hispanic or Latino Veteran: \_\_\_\_Yes \_\_\_\_No** | | | |

**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**  **(OPTIONAL)** | **Work**  **YES/NO** |
| **1** |  | **SELF** |  |  |  |  |  |
| **2** |  |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |  |
| **8** |  |  |  |  |  |  |  |

**SECTION BELOW FOR INTERVIEWER**

|  |  |  |
| --- | --- | --- |
| **Interviewer:** | **Date Issued: \_\_\_\_\_\_\_\_\_\_\_\_\_** | **Expiration Date:** |
| **Annual Income: $** | **Monthly Income: $ \_\_\_\_\_\_\_\_\_\_\_** | **Sliding Scale Classification: \_\_\_\_\_\_\_** |

🞏 **New Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 🞎 **Application Renewal**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is any member of your family receiving any of the following?**

***Please indicate Yes or No for each item:***

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

***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 service.***

**Print Name Signature Date**

|  |
| --- |
| **SECTION BELOW FOR INTERVIEWER** |

**NOTES:**

**ID: *(Husb) (Wife)***

**POA: *(Husb) (Wife)***

**POI:**

***Please indicate if child has Medicaid, CHIP, and if Birth Certificate was presented:***

|  |  |
| --- | --- |
| ***Birth Certificate:*** |  |
| ***Medicaid:*** |  |
| ***CHIP:*** |  |

**501 (C) 3 Nonprofit Organization A Ministry of the Archdiocese of Galveston-Houston A United Way Agency**