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 _____ E-mail _____

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

Emergency Contact Person _____ Relationship _____

Contact Person Phone # (_____) _____ Home Work or Cell _____
Race: Caucasian* African-American* Hispanic* Other _____ **Gender:** Male Female
Marital Status: Married, Single, Widowed, Divorced, Separated **Do you have any Insurance?** No__ Yes___
Household Size: # Adults: _____ # of Dependents (claimed on taxes) ____
Do you work?_____ **Where?**_____
For the Medication Assistance Program, we need to know if you filed taxes last year? 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?: Yes ____ No ___ Do you have Prescription Coverage Yes ___ No ____
Are you presently enrolled in the Medication Assistance Program? Yes ____ No____

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

The above information is true to the best of my knowledge. I understand that the free clinic staff may need to verify certain information, and I understand that withholding information or giving false information will make me ineligible for care and medication at the clinic. I also understand that to remain eligible for the Clinic's services I must provide updated information every 12 months. I agree to notify the Clinic immediately if my household income, household size or insurance status changes.

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

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

Revised 05/04/2022