COMMONSHARE Patient Eligibility Form - (804)416-6255

(Rev 10/13/21)

NAME: _____
Last First M.I.

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE (H): _____ **CALL/MESSAGE?** ☐ YES ☐ NO

MOBILE PHONE: _____ **TEXT?** ☐ YES ☐ NO

EMAIL: _____

PREFERRED CONTACT: ☐ HOME PHONE ☐ MOBILE PHONE ☐ EMAIL

EMERG. CONTACT: _____ **PHONE:** _____

DATE OF BIRTH (mo/day/year):

SOCIAL SECURITY #:

SEX: ☐ FEMALE ☐ MALE

ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC

LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____

Are you employed? ☐ **YES** ☐ **NO**

If YES, Where? _____

☐ Full-time ☐ Part-time ☐ Seasonal

Self-Employed? ☐ **YES** ☐ **NO**

Unemployed? ☐ **YES** ☐ **NO**

If YES, Why?

☐ Disabled ☐ Retired ☐ Homemaker
☐ Due to health ☐ Unable to find work

Race:
☐ White
☐ Black
☐ Hispanic
☐ Other: _____

Marital Status:
☐ Married
☐ Single
☐ Divorced
☐ Widowed
☐ Cohabitate

Medical Insurance Status:
☐ APPLIED for Medicaid
☐ Medicaid
☐ VA Benefits
☐ Medicare
☐ Private Insurance
☐ NONE

If Homeless,
☐ Shelter
☐ Street
☐ Live w/ others

Active Workman's Compensation?
☐ YES ☐ NO

Drug Allergies: ☐ YES ☐ NO
If YES, List:

If you receive Social Security Benefits:
☐ SSI ☐ RETIREMENT ☐ DISABILITY

IMPORTANT: Proof of household income may be requested more than once per year.

Do you receive SNAP (food stamp) benefits? ☐ YES ☐ NO If yes, how much? $_____

# of People in the Household: _____

Name of Household Member	Age	Relationship to Patient	Income Source (Job, SS, etc.)	Gross Monthly Amount
Patient:		SELF		$
				$
				$
				$
				$
			Total:	$

PATIENT AGREEMENT/DISCLOSURE:

Being truthful and of sound mind I attest I do / do not have prescription drug coverage. I agree to allow the —— Clinic and Commonshare to complete any patient assistance enrollment process on my behalf, which may include disclosure of personal and medical information. I also authorize the —- Clinic and Commonshare to share medical and financial information with any and all pharmaceutical providers for eligibility and audit purposes. I will immediately notify the — Clinic and Commonshare of any changes to my income, household size, or insurance status.

Signature: _____

Date: _____

For Staff Use ONLY:

	Date	Initials
Application :		
Consent Form:		
Photo ID		
Social Security Card:		
IRS Form:		
POI:		
Letter of Support:		

Percent Below FPL:
◊ Below 200%
◊ 200% - 300%
◊ 300%-400%
◊ Above 400%

Expires: _____

Issued by: _____

Date: _____

☐ **NOT ELIGIBLE:** _____

Patient ID: