TRINITY COMMUNITY CARE

Eligibility Form

Clinic Use Only:

PRN: _____

MRN: _____

Confidentiality:

All information is kept strictly confidential and is not provided to any outside third parties except as may be required to verify eligibility or by the Michigan Public Health Code, State and Federal regulations. By completing this form you acknowledge that the information is freely given and that you have not been compelled to provide any of the information requested. However, you further acknowledge that Trinity Community Care is a free clinic offered as a service to the community; therefore the information provided will be used to determine your need, priority and qualification for services requested. If information is not provided you may be denied services.

Nonemergency Services:

You understand that Trinity Community Care is only authorized to provide nonemergency health care without compensation and only inside the premises of Trinity Community Care. Trinity Community Care does have a collaborative agreement with Beaumont Health Systems to provide lab work, x-rays and other diagnostic procedures for no cost to you. If additional services or referrals are required, Trinity Community Care may provide assistance in arranging for said services; however, you will be required to make the final arrangements and Trinity Community Care is not responsible for the cost of any off premise services.

Applying for: ☐ **Medical** ☐ **Dental** ☐ **Both**

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **M.I.:** _____

Street Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security #: _____ **Date of Birth:** _____ **Age:** _____

Driver's License or State ID #: _____

Primary Phone #: _____ **Alt Phone #:** _____

Email Address: _____

What is the best way to reach you? ☐ **Phone** ☐ **Text** ☐ **Email** ☐ **Other** _____

Emergency Contact: _____

Phone: _____ **Relationship:** _____

DEMOGRAPHIC INFORMATION

Gender

☐ **Male** ☐ **Female**

Ethnicity

☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**

Race

☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian or other Pacific Islander** ☐ **White**

Marital Status

☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Other** _____

Military Status

☐ **Active Duty** ☐ **Veteran** ☐ **Retired** ☐ **Dependent**

Disabled

☐ **Yes** ☐ **No** **If yes, please note:** _____

TRINITY COMMUNITY CARE

Eligibility Form

Clinic Use Only:

PRN: _____

MRN: _____

LIVING SITUATION

Rent	☐	House	☐	Apartment	☐	Lot	☐	Room
Own	☐	House	☐	Mobile Home	☐	Land	Amount? _____	
Buying	☐	House	☐	Mobile Home	☐	Land	Amount? _____	
Homeless	☐	Car	☐	Street	☐	Shelter	Where? _____	
Staying with friend/relative	☐	Who/Where? _____	How Long? _____	Do you pay rent?	☐ Yes	☐ No		

EMPLOYMENT INFORMATION

☐ **Employed - Full Time**

☐ **Employed - Part Time**

Number of Part Time Jobs _____

Average Hours Worked per Week _____

☐ **Full or Part Time Work is Seasonal**

☐ **Self Employed**

☐ **Retired**

☐ **Unemployed**

How long? years ____ months ____

Anticipated return to work? _____

Unemployed due to health reasons? ☐ Yes ☐ No

If yes, please explain: _____

Other reasons for unemployment? _____

INCOME AND EXPENSE SUMMARY

Gross Monthly Income		
Source	**Patient ($)**	**Spouse/Other ($)**
Wages/Salary		
Pension		
Social Security		
SSI		
Disability		
Unemployment		
Other:		
Total Monthly Income ($):		

Monthly Expenses	
Source	**Amount ($)**
Mortgage/Rent	
Utilities	
Phone	
Food	
Transportation	
Other(s):	
Total Monthly Expenses ($):	

Medical Expenses NOT covered by insurance or other third party	
Source	**Monthly Expenses ($)**
Doctor	
Lab/Other	
Medications	
Other:	
Total ($):	

# of Persons dependent on this income: _____

# of Adults (over age 18): _____ # of Children (age 18 and under): _____

TRINITY COMMUNITY CARE

Eligibility Form

Clinic Use Only:

PRN: _____

MRN: _____

INSURANCE INFORMATION

Medical Insurance: Do you have or have you applied for Medical Insurance Coverage? ☐ Yes ☐ No

Insurance Name: _____ **Policy #:** _____

Annual Deductible: _____ **OR Monthly Deductible:** _____

Have you applied for Medicare or Medicaid? ☐ Yes ☐ No **If yes, when?** _____

Were you denied? ☐ Yes ☐ No **If yes, when?** _____

Active	Pending		Active	Pending		Active	Pending	
☐	☐	Employer Insurance	☐	☐	Private Insurance	☐	☐	Medicaid/MI-Child
☐	☐	Medicare	☐	☐	VA	☐	☐	Other _____

Medication Coverage? ☐ Yes ☐ No

If you have medical coverage, please explain: _____

Dental Insurance: Do you have or have you applied for Dental Insurance Coverage? ☐ Yes ☐ No

Insurance Name: _____ **Policy #:** _____

Annual Deductible: _____ **OR Monthly Deductible:** _____

SIGNED AGREEMENT

I attest that all statements recorded on this document are true and correct to the best of my knowledge. I understand that I may be asked for additional documentation in support of these statements. I authorize Trinity Community Care to release to third parties any information necessary to establish my or my family's eligibility. I understand this information may include medical or non-medical information including sources such as employers. This authorization may be reproduced.

Signature: _____ **Date:** _____