

Free Clinic of Pulaski County – Eligibility

Patient Name: Last _____ First _____ Middle _____

Address _____

Telephone () _____ SS# _____ DOB _____ AGE _____

Male _____ Female _____ Caucasian _____ African American _____ Hispanic or Latino _____ Asian _____ Other _____

Do you have insurance? _____ Do you have Medicare or Medicaid? _____ Are you a Veteran? _____

Marital Status: Single _____ Married _____ Do you reside in a home with others? _____

Is there children in the home either full time or part time? _____

What is the total number of people living in your home including yourself? _____

Do you work? _____ Full time _____ Part time _____ Sometimes _____

Employer Name: _____

Did you file taxes last year? _____ Does anyone else in the home work? _____ Does anyone in the home receive unemployment, Social Security, SSI? _____ Is anyone on Disability? _____ For how long? _____

Does anyone in the home receive a pension, child support or alimony? _____

I understand and agree to the following:

I will be respectful and considerate of staff. I will conduct myself in a non-threatening (physical or verbal) manner whether on site, over the phone or in written communication. I understand that violation of proper behavior is cause for immediate dismissal as a patient at the Free Clinic of Pulaski County.

I will inform the Free Clinic immediately of any changes in my household such as income, marital status, telephone number or address changes. Any deception found to receive services under fraudulent means will result in dismissal from the practice.

I understand that each new calendar year I am required to provide a federal 1040 for all household members. If I do not file income tax then I will provide any and all W2's. Failure to do so will result in dismissal from the practice.

Pulaski Free Clinic asks for a \$2.00 donation upon arrival for your appointment. If you can not afford a donation, please know that you can still receive your medical care.

Signature: _____ Date: _____