



## ELIGIBILITY SCREENING

### BASIC HEALTH CARE • CHARITY • DISCOUNT • SLIDING FEE PROGRAM

Last Name	First Name	Middle Name	Date of Birth	Gender
Home Address (include apt. number)		City/State/Zip	Home Phone ( )	Ethnicity
Mailing Address (if different than home address)		City/State/Zip	Mobile Phone ( )	Primary Language
Number of Immediate Family Members Living in Your Home (Count Yourself, Spouse, Children–If the Applicant Is a Child Count Child, Parents, Brothers and Sisters):				
<b>Marital Status</b>				
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Maiden Name:		Mother's Maiden Name:	
	Name of Spouse or Domestic Partner		Is Your Spouse Living with You?	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> No	
<b>Current Housing Status</b>				
Are you currently experiencing housing instability or do you lack a permanent place to live?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you currently reside with someone who provides you with free room and board?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If <b>yes</b> , Name:		Relationship:		
Address:		City/State/Zip:		

## EMPLOYMENT and BENEFITS SCREENING

\*\*ADDITIONAL PATIENT INFORMATION \*\*

Please answer all questions\*Contra Costa Health's mission is to care for and improve the health of all people in Contra Costa County with special attention to those who are most vulnerable. This information will help Contra Costa Health access additional grants to continue helping insured and underserved residents in our communities. This information also helps us identify clients who may qualify for specialty funded programs or services you may qualify for. This information will become a part of your confidential medical record.

Please answer **ALL** applicable questions below about the **primary applicant**. This information is only used to find out if the primary applicant is eligible for the Basic Health Care Program or other programs that provide health coverage.

Offered health coverage/insurance through an employer?*		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of Insurance:	Group #:	Policy #:	
Billing Address:	City/State/Zip:		
Are you a U.S. citizen?*	If you answered yes, skip the following question	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you a Lawful Permanent Resident <sup>1</sup> ?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If <b>yes</b> , city & state where born:			
If <b>yes</b> , how many years have you been a Lawful Permanent Resident <sup>1</sup> ?			
Permanent Resident Alien Card or I-94#:		Issue Date:	Exp. Date:
Social Security # – Leave Blank If N/A:			
Employment Authorization or Work Permit #:		Student or Visitor Visa #:	
Are you pregnant?	N/A	Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a refugee living in the U.S. for less than 9 months?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you now disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If <b>yes</b> , have you been or do you expect to be disabled for 1 year or longer?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you applied for Social Security Disability or SSI? DATE APPLIED:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you applied for Medi-Cal because you are disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have children living in your home who are under 21 years of age?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If <b>yes</b> , are both parents living in the home?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If both parents live in the home, are both parents working full-time?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Is either parent unemployed or temporarily unable to work for 30 days or more or working part-time?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Is either parent legally blind or permanently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If you are not the parent, are you a relative of the child(ren) and have legal custody?			<input type="checkbox"/> Yes <input type="checkbox"/> No

\*Indicates a required field.

1. Are you a Lawful Permanent Resident? A Lawful Permanent Resident (LPR) is not a U.S. citizen. An LPR is an immigrant who resides in the U.S. under a legally recognized permanent residence status. Examples include Green Card Holders, Permanent Resident Aliens, and Resident Alien Permit Holders.

Are you now receiving Medi-Cal or Medicare? Medi-Cal or Medicare #:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you now receiving Social Security Disability or SSI?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date you began receiving benefits:		

### HOUSEHOLD INCOME

IF THE APPLICANT IS A CHILD, USE PARENTS' INCOME/ASSETS FOR ALL FINANCIAL QUESTIONS ON THIS FORM

List employment information below for both you and your spouse (or for your parents). If you have more than one job, attach a separate piece of paper with that information. If you do not work, tell us where and when you worked last:

WHERE:	YOUR (OR PARENT'S) JOB INFORMATION	WHEN:
	YOUR (OR PARENT'S) JOB INFORMATION	SPOUSE'S (OR PARENT'S) JOB INFORMATION
Employer's or business name		
Employer's or business address		
Type of employment		
Gross earnings per pay period (include tips)		
How often paid	<input type="checkbox"/> Monthly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks	<input type="checkbox"/> Monthly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks

Complete this section if you are self-employed

Adjusted gross income/last tax statement	Income change since the last tax statement?	Estimated annual profit	Checking/savings bus. Acct. Balance	Average annual cash bus. Expenses
\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	\$

Do you or your spouse pay court-ordered child/spousal support?  
 If **yes**,  self  Spouse paid \$ \_\_\_\_\_ this month to:  Yes  No

Please list the amount of income you or your spouse (parents of child) receive monthly from any of the following:  
 If you have no source of income or support, please enclose a written statement as to how you are supporting yourself.

\$ Child Support	\$ General Assistance	\$ Interest Earned Income
\$ IRA	\$ Loans or Grants	\$ Pension
\$ Railroad Retirement	\$ Soc. Sec. Disability	\$ Soc. Sec. Retirement
\$ Spousal Support	\$ SSI/SSP	\$ State Disability Ins.
\$ Strike Benefits	\$ Training Payments	\$ Unemployment
\$ Workers Comp.	\$ Other	

By signing this form, I affirm that the information I have provided is accurate and complete. I understand that any inaccuracies or omissions may result in the revocation of any health coverage subsidy from Contra Costa Health. Furthermore, by signing, I acknowledge that I have read, signed, and received a copy of the "Rights and Responsibilities" associated with the Contra Costa Health programs. I am aware that a financial counselor from Contra Costa Health will evaluate this screening tool to assess my eligibility for various programs, and I will receive written notification of the outcome.

\_\_\_\_\_  
**Signature Required** of Applicant (Parent)

\_\_\_\_\_  
 Date of Application

\_\_\_\_\_  
 If Applying for a Child, Print Name of Parent

\*Indicates a required field.

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