

COACHELLA VALLEY VOLUNTEERS IN MEDICINE (CVVIM)

2018 PATIENT ELIGIBILITY FORM

(Please Print)

Today's Date: / /	Patient's Name: Last: First: Middle:
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HOUSEHOLD SIZE AND INCOME VERIFICATION

Number of People in Your Household	Annual Income for <u>all</u> Persons in the Household (200% of 2016 FPL)
1	\$0 - 24,120
2	\$24,121 - 32,480
3	\$32,481 - 40,840
4	\$40,841 - 49,200
5	\$49,201 - 57,560
6	\$57,561 - 65,920
7	\$65,921 - 74,280
8	\$74,281 - 82,640

Patient's Household Size: _____ **Patient's Household Annual Income:** \$ _____

- Proof of Income:**
- Paycheck(s) (make copy for file)
 - Previous Year's Tax Return(s) (make copy for file)
 - W-2 (s) (make copy for file)
 - Other: _____ **Paid in Cash?** YES NO

ADDITIONAL INFORMATION

Education: <input type="checkbox"/> High School Diploma/ GED <input type="checkbox"/> Grades K-6 <input type="checkbox"/> Grades 7-12 <input type="checkbox"/> No School <input type="checkbox"/> Some College <input type="checkbox"/> College Graduate	How did you get to CVVIM: <input type="checkbox"/> Bus <input type="checkbox"/> Car <input type="checkbox"/> Friend or Family <input type="checkbox"/> Taxi <input type="checkbox"/> Walk <input type="checkbox"/> Other _____ US Veteran: <input type="checkbox"/> YES <input type="checkbox"/> NO	Does your employer offer health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, are you covered? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, was it for an emergency only? <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever applied for Health Care with? Medi-Cal <input type="checkbox"/> YES <input type="checkbox"/> NO Medically Indigent Services Program (MISP) <input type="checkbox"/> YES <input type="checkbox"/> NO Covered California <input type="checkbox"/> YES <input type="checkbox"/> NO Private Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, are you covered? Medi-Cal <input type="checkbox"/> YES <input type="checkbox"/> NO (MISP) <input type="checkbox"/> YES <input type="checkbox"/> NO Covered California <input type="checkbox"/> YES <input type="checkbox"/> NO Private Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO	Person who completed the application: Signature: _____ Name: _____ Date: ____/____/____

Name of CVVIM Volunteer/Staff who reviewed the application:

Printed Name: _____ Date: ____/____/____