Client Eligibility Registration Form

Name _____ Phone _____

Date of birth _____ SS#_____ Sex ___F ___M

Alien Number _____ Hispanic ___Yes ___No Race _____

Marital Status ___Single ___Married ___Divorced ___ Separated ___ Widow/Widower

Home Address _____ City _____State ___Zip _____

Mailing Address _____ City _____State ___Zip _____

Please list everyone living in your home

Name	Date of birth	SS#	Relationship

Please list everyone with any type of income in your family

Including all jobs, pensions, child support, social security, death benefit, alimony, unemployment/worker's compensation, veteran benefits, investments, trust funds, rental income, and self employment, Public Assistance, grants or any other income received.

Name	Employer or type of income	Monthly gross income

Please answer the following questions

Does any family member have Medicare coverage? ___Yes ___No Medicare Part D? ___Yes ___No

Does any family member have Medicaid coverage? ___Yes ___No

Have you applied for Medicaid coverage? ___Yes ___No

Do you have any medical coverage/health insurance? ___Yes ___No

Are you enrolled in an HMO? ___Yes ___No

Are you pregnant, a new mother, or received a pregnancy related service in the past 2 years? ___Yes ___No

Are you paying child care? ___Yes ___No

Do you have a court order to pay child support for a child not in your home? ___Yes ___No

Do you have children under age 21 in your home? ___Yes ___No

Are you homeless or living temporarily with others? ___Yes ___No

Are you a veteran? ___Yes ___No Are you disabled? ___Yes ___No Are you over 55 years of age? ___Yes ___No

I affirm that the information that I am providing is true and correct. I understand that if I provide false or inaccurate information that services may be discontinued and I will have to pay for all services received according to the fee schedule. FAC64f10.003(5).

Signature _____ Date _____