

Sarasota Healthcare Access Client Eligibility Registration Form

North County FAX: 941-861-2705 South County FAX: 941- 861-3394

Name _____

Date of birth _____ SS# _____ Sex F M

Alien Number _____ Hispanic Yes No Race _____

Marital Status Single Married Divorced Separated

Address _____

_____ Phone _____

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 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 If yes, Name of HMO: Amerigroup Staywell Healthease Other

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 _____