

**LCFC PATIENT APPLICATION
PATIENT INFORMATION
PLEASE PROVIDE PROOF OF INCOME**

NAME: _____ SPOUSE'S NAME: _____
 DOB: _____ AGE: _____ SOCIAL SECURITY #: _____ - _____ - _____
 ADDRESS: _____ CITY: _____ ZIP CODE: _____
 COUNTY: _____ SEX: _____ (M/F) RACE: _____
 MARITAL STATUS: MARRIED: _____ SINGLE: _____ DIVORCED: _____ SEPARATED: _____ WIDOWED: _____
 REFERRAL SOURCE: _____

PHONE NUMBERS:

HOME: _____ WORK: _____ EMERGENCY CONTACT: _____

ELIGIBILITY:

MEDICAID: YES ___ NO ___ MEDICARE: YES ___ NO ___ MILITARY? YES ___ NO ___ MEDICAL INSURANCE: YES ___ NO ___
 WERE YOU EVER ON WELFARE? YES ___ NO ___ DATE LAST RECEIVED: _____
 REASON WELFARE ENDED: _____
 HAVE YOU EVER BEEN SEEN AT THE FREE CLINIC? YES ___ NO ___ IF YES, WHEN? _____
 HAVE YOU EVER BEEN SEEN AT LORAIN COUNTY HEALTH AND DENTISTRY/FAMILY CARE CENTER? YES ___ NO ___

PATIENT

EDUCATION _____ YRS _____ STUDENT: YES ___ NO ___ SCHOOL: _____

INCOME: PLEASE COMPLETE!!!

| | | |
|---------------------------------|------------------------|----------------------|
| EMPLOYED? | EMPLOYER: | OCCUPATION: |
| HOURLY WAGE: | HOURS WORKED PER WEEK: | EMPLOYER'S PHONE: |
| RETIRED? | FROM WHERE? | ARE YOU DISABLED? |
| CHILD SUPPORT OR ALIMONY? | AMOUNT: | SPOUSE EMPLOYED? |
| SPOUSE'S EMPLOYER: | HOURLY WAGE: | HOURS PER WEEK: |
| SPOUSE DISABLED? | SPOUSE RETIRED? | FROM WHERE? |
| TOTAL MONTHLY HOUSEHOLD INCOME: | | NUMBER IN HOUSEHOLD: |

HOUSEHOLD INFORMATION (ALL OTHERS IN HOUSEHOLD)

| NAME: | DOB: | SS NUMBER: | EMPLOYER: | RELATIONSHIP: | INCOME PER YEAR: |
|-------|------|------------|-----------|---------------|------------------|
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OTHER HOUSEHOLD INCOME: _____ WEEK: _____ MONTH: _____ YEAR: _____ OTHER: _____
 CHECKING ACCOUNT: YES ___ NO ___ SAVINGS ACCOUNT: YES ___ NO ___

I UNDERSTAND THAT THE ABOVE INFORMATION WILL BE VERIFIED. YOUR SIGNATURE: _____

I NEED TO COME TO THE CLINIC FOR: _____

LORAIN COUNTY FREE CLINIC 3323 PEARL AVE. LORAIN, OHIO 44055

SCREENER'S SIGNATURE: _____ DATE: _____