DH1032E

1. You should be able to determine from the Patient Needs Survey whether the patient has insurance. Check yes or no in section 1. Note: The only insured patients we accept are those who have Medicaid Share of Cost which has a very high monthly deductible.

2. Ask if any household member has Medicaid. If so, find out who and record their Medicaid number on line 2.

3. Type the name as it appears on their ID including middle name(s). If ID does not have current address, get current address from the patient.

4. FAMILY MEMBERS:
   - Your questionnaire should list every member of the patient's household but only the family unit is listed on the DH1032E. Husband, wife and minor children are obvious as a family unit. DON'T FORGET TO LIST THE MINOR CHILDREN! ONLY 2 ADULTS CAN BE LISTED HERE.

5. LESS OBVIOUS FAMILY UNIT:
   - Engaged couple and their minor children, if any, living with them—family unit
   - Boyfriend/girlfriend or same sex couple and any of their minor children, if any, living with them—family unit.

6. NOT A FAMILY UNIT:
   - Patient living with a friend (not boyfriend/girlfriend situation)—Not a family unit.
   - Patient lives with relative(s) such as adult sister, brother, nieces, nephews or elderly mother or father.—Not part of patient's family unit.
   - Note: These people will be listed on the questionnaire but not on the DH1032E

7. If patient's monthly income is just over the financial limits, use the steps in section 7 to see if they can still qualify.

8. The only date format the form accepts is 2 characters for the date and 4 characters for the year with a virgule in between such as 05/02/2021. If it is not entered correctly it will not show up on the printed document.

Revised 10/4/2021

VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM

CLINIC/PROGRAM/PROVIDER: FLAGLER COUNTY FREE CLINIC

Section 1

1. Does the client/patient have insurance that covers the health or dental condition? YES ☐ NO ☐

2. Does anyone in the client/patient's family have an active FL Medicaid card? YES ☐ NO ☐

Name of the card holder and Medicaid No. ______________

3. Client/Patient/Head of Household's Name: ______________
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: ______________
(STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: ______________ Name of Contact: ______________

Section 2

4. **Family Size: Adults____ Under 18 ____ 18-21--Student ____ Unborn ______ Family Size TOTAL ______**

5.

6.

FAMILY MEMBERS NAME (First and Last)	DOB	EMPLOYER	GROSS EARNED INCOME LAST 4 WKS	GROSS UNEARNED INCOME LAST 4 WKS (Do not include TCA or SSI)
SELF			$	$
SP/PART			$	$
CHILD			$	$
CHILD			$	$
CHILD			$	$
CHILD			$	$
		TOTALS	$	$
		Add earned and unearned income to determine total		TOTAL INCOME $______

7.

Section 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)

7.

Step 1.	**"TOTAL FAMILY INCOME"** for family unit (Earned and unearned income).	(1) $______	(Above)
Step 2.	Subtract $90 for EACH employed member of the family unit.	(2) $______	(Minus)
		(2a) $______	(Total)
Step 3.	Subtract childcare PAID each month (up to $175 per child age 2 and older; up to $200 per child under age 2).	(3) $______	(Minus)
		(3a) $______	(Total)
Step 4.	Subtract up to $50 per month of total child support received.	(4) $______	(Minus)
Step 5.	**TOTAL NET INCOME**	(5) $______	(Total)

Section 4 USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit. I acknowledge receipt of the Department of Health's Notice of Privacy Practices.

______________ ______________

SIGNATURE OF CLIENT/PATIENT/PARENT OR GUARDIAN AND DATE **PRINT NAME OF DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE**

8. (VALID FOR ONE YEAR) Expiration date: ______________ 8.