



Account Number: _____

SS# _____

Patient Email Address: _____

DOB: _____

Patient Demographic

Same as Demo

Last, First: _____

Maiden Name: _____

Street: _____

City, State: _____

County & Zip: _____

Mailing Address
(if different from above) _____

Phone: _____

Cell: _____

Citizenship Status

- US
- Legal Resident Entry Mo/Yr _____
- Work Permit
- VISA (Student/Tourist/Business)
- Foreign Citizen (72 hour Pass)
- Undocumented
- Refugee/Asylee From _____
- Place of Birth: _____
- Patient Primary Language: _____
- Mother's Maiden Name: _____
- Father's Name: _____
- Difficulty Reading/writing? Y N

Guarantor

Same as Patient

Guarantor: _____

DOB: _____

SS#: _____

Street: _____

City, State: _____

County & Zip: _____

Phone: _____

Cell: _____

If PO Box need physical _____

Household Composition

Patient's Marital Status

- Single Married Divorced Widowed Separated (how long) _____

Spouse Information

Spouse Name: _____ DOB: _____

SS#: _____ US Citizen Legal Resident Yr Undocumented

Tax Calculations

Did applicant file taxes in prior year? Y N Will they file? Y N

Under what status? Single Married/ Jointly Married/ Separate

Adj Gross Income _____ # Dependents Claimed? _____

Were you claimed as a tax dependent by someone? Y N

Relationship to Tax Filer who claimed you? _____

Child 1: Dir Related Step Child

Dependent Claimed

Name: _____

DOB: _____

SS# _____

US Citizen: Yes No

Sex: M F

Coverage? MCD Ins None

Child 2: Dir Related Step Child

Dependent Claimed

Name: _____

DOB: _____

SS# _____

US Citizen: Yes No

Sex: M F

Coverage? MCD Ins None

Child 3: Dir Related Step Child

Dependent Claimed

Name: _____

DOB: _____

SS# _____

US Citizen: Yes No

Sex: M F

Coverage? MCD Ins None

Child 4: Dir Related Step Child

Dependent Claimed

Name: _____

DOB: _____

SS# _____

US Citizen: Yes No

Sex: M F

Coverage? MCD Ins None

Patient Income

Employed Self-Employed Cash/Day Work Unemployed (Since _____) Employer: _____

Hourly \$ _____ Hrs/PP: _____ Salary Rate \$ _____

Employer Phone: _____

Frequency Paid: Weekly (x 4.33) Bi-Weekly (x 2.17) Semi-Monthly (x 2.00) Monthly

Length of Employment: _____ Mo Yrs

Est. Mo. Income \$ _____ Last check received \$ _____ Income DOS Month \$ _____

Spouse Income

Employed Self-Employed Cash/Day Work Unemployed (Since _____) Employer: _____

Hourly \$ _____ Hrs/PP: _____ Salary Rate \$ _____

Employer Phone: _____

Frequency Paid: Weekly (x 4.33) Bi-Weekly (x 2.17) Semi-Monthly (x 2.00) Monthly

Length of Employment: _____ Mo Yrs

Est. Mo. Income \$ _____ Last check received \$ _____ Income DOS Month \$ _____

Does patient or spouse have insurance available thru employer but declined coverage due to cost? Y N If yes, what was monthly premium? _____

Has patient or spouse lost health coverage from an employer in the last 60 days? Y N SEP Eligible? Y N COBRA Eligible? Y N Cost for COBRA? _____

Other Income

Count

for MAGI Programs

Unemployment \$ _____ Widow's/Survivor's Benefits \$ _____

SSD \$ _____ How Long Until MCR _____ Other \$ _____

Retirement / Pension \$ _____ Cash Assistance \$ _____

Cash Assistance Received from: _____

Do Not Count

for MAGI Programs

Child Support \$ _____ Court-Ordered Voluntary

SSI \$ _____ MCD Benefits Y N Food Stamps \$ _____

VA Benefits \$ _____ Workers Comp \$ _____ GI Bill \$ _____

Patient Resources (Do Not Count for MAGI Programs)

Checking \$ _____ Institution: _____ Savings \$ _____ Institution: _____

Auto 1 <input type="checkbox"/> Own <input type="checkbox"/> Financed Pymt \$ _____ <input type="checkbox"/> Leased Yr: _____ Make: _____ Model: _____	Auto 2 <input type="checkbox"/> Own <input type="checkbox"/> Financed Pymt \$ _____ <input type="checkbox"/> Leased Yr: _____ Make: _____ Model: _____	Auto 3 <input type="checkbox"/> Own <input type="checkbox"/> Financed Pymt \$ _____ <input type="checkbox"/> Leased Yr: _____ Make: _____ Model: _____
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Any Additional Assets: Stocks \$ _____ Bonds \$ _____ Retirement / 401(k) \$ _____ IRA \$ _____

Burial Plot \$ _____ Life Ins \$ _____ Real Property \$ _____ Boat / RV / ATV \$ _____ Other _____

Patient Expenses

Home: Own Rent Mortgage / Lease Amt \$ _____

Staying with _____

Food: Avg. Mo. Exp. \$ _____ Phone _____

Gas: Avg. Mo. Exp. \$ _____ Home \$ _____

Medications: Avg. Mo. Exp. \$ _____ Cell \$ _____

Electricity: Avg. Mo. Exp. \$ _____

Water: Avg. Mo. Exp. \$ _____

Patient Deductions

Alimony Paid \$ _____

Student Loan Interest \$ _____

Educator Expenses \$ _____

Health Savings Account (HSA) \$ _____

IRA Deductions \$ _____

Self-Employment Business Exp \$ _____

Young Adult

Is Patient under age of 26? Y N

Does patient have a parent with employer sponsored health insurance? Y N

Date of parent's open enrollment period? _____

Is patient a former foster care child and now between the ages of 18 and 26? Y N

Hospitalization

Admitting Diagnosis: _____ Treating Diagnosis: _____

If diagnosis is Breast or Cervical Cancer, is this initial diagnosis/treatment? Y N Other Medical Conditions: _____

Is Patient Pregnant <input type="checkbox"/> Y <input type="checkbox"/> N Due Date: _____	Related to Accident <input type="checkbox"/> Y <input type="checkbox"/> N (If Y was pt at Fault) <input type="checkbox"/> Y <input type="checkbox"/> N Date of Accident: _____ <input type="checkbox"/> MVA <input type="checkbox"/> TPL Ins. Name: _____ Ins. Phone: _____ Claim # _____ Policy # _____ At Fault Party Information Ins. Name: _____ Ins. Phone: _____ Claim # _____ Policy # _____
Related to Work? <input type="checkbox"/> Y <input type="checkbox"/> N	

Related to a crime Y N Police report filed Y N Agency Reported to: _____ Report/Incident # _____

Date of Incident _____ Brief Description of Crime _____

Applied for disability Y N RSDI SSI

Stage: Initial Recon Hearing Original File Date: _____ Alleged onset date: _____

Disability Attorney/Rep: Y N Name of Representative: _____ Phone: _____

Does patient claim to be disabled? Y N Is patient able to work? Y N Usual Occupation? _____ Yrs of Exp? _____

Does patient plan on returning to work? Y N Highest Level of Education Completed: Elementary Middle School High School GED Tech Cert. Degree College/Grad

Patient must answer yes to all four questions in order to qualify for Mill Bill Reimbursement

Is the patient a veteran? N Y

Is the patient reg. in the VA Health Care System? N Y

Has patient recvd services through the VA in last 24 mo's? N Y

Did patient receive Emergency Service at your facility? N Y

Have you applied for MCD before? Y N If yes, when? _____

Case Worker Name: _____

Does anyone in your household, including yourself, smoke tobacco? How many? Y N

of people _____?

Regional Questions

Are you on CHIP Perinatal? N Y CHIP ID # _____ Below 185% Above 185%

Are you currently on a county program? N Y Name of County Program: _____
Example: Gold Card/MAP/Ector County

Patient Signature: _____ Date: _____ Witness: _____ Date: _____