707 Murchison Road, Suite 3
Fayetteville, NC 28301
(P) 910.483.6869 (F) 910.483.5898
chnnc.org

# PATIENT ELIGIBILITY FORM 

***Please print clearly and complete all categories***

Date:_____ Date of Birth: _____

**Name:**

Last _____ First _____ MI_____

**Address:**

Street_____ City _____ Zip Code _____

**Length of time at current address:**_____ **Phone Number:**_____

**Alternate Contact #:** _____ **Social Security Number:** _____-____-_____

**Driver's License State & Number:**_____

Gender: ___ M ___ F **Marital Status:**_____ **Military Veteran:** ___ Yes ___ No

**Race:** (*Please check one*) ___ **American Indian** ___ **Asian** ___ **Black/African American**
___ **White** ___ **Pacific Islander** ___ **Multi-Race** ___ **Hispanic**

**# in Household:** _____ **Female Head of Household:** ___ Yes ___ No **# of minors in HH**:_____

**Diagnosis:** ___ **CHF** ___ **HTN** ___ **DM** ___ **Asthma** **Other:** _____

**Health Insurance:** ___**BCBS** ___ **United** ___ **Medicaid** ___ **Medicare** ___ **None** ___ **Other**

**Applied for Medicaid in past year?** ___ **Yes** ___**No** **If yes, outcome?** ___ **Denied** ___ **Pending**

**Medical/Dental Information:**

In the last 12 months, have you been seen by the Emergency Room: ___ **Yes** ___ **No**

If yes, please describe when, where, and the reason for the visit:_____

CUMBERLAND HealthNET

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# PATIENT ELIGIBILITY FORM (page 2 of 3)

**Dependent/Spouse Information:**

| List the names of your spouse and any legal dependents you have. Place an X in the first column for any family member | | | | | | |
|---|---|---|---|---|---|---|
| **X** | **Names** | **Date of Birth** | **Race** | **Sex** | **Relationship** | **SS# or ITIN#** |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Applicant Employment Information:**

Employed: ___ **Yes** ___ **No** **Job Title:** _____

Employer's Name & Address: _____

How many hours do you work each week?_____ How often are you paid?_____

How much do you make per hour? $ _____ How much were you paid last month? $_____

Does your employer offer insurance? ___ **Yes** ___ **No** ___ **N/A**

**Do you or any household member you've listed receive any of the following income?**

| Income type | Yes | No | If yes, who? | Amount | How often? |
|---|---|---|---|---|---|
| Self-Employment | | | | | |
| Contributions | | | | | |
| Wages | | | | | |
| Earned Income | | | | | |
| Public Assistance | | | | | |
| Social Security | | | | | |
| Social Security Disability | | | | | |
| Unemployment/Disability | | | | | |
| Worker's Compensation | | | | | |
| Alimony | | | | | |
| Child Support | | | | | |
| Retirement/Railroad | | | | | |
| Military Allotment | | | | | |
| VA Benefits | | | | | |
| Interest/Dividends | | | | | |
| Grants/Scholarships | | | | | |
| Other Income | | | | | |

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**If you have no household income, explain how you pay your bills. Include names and phone numbers of people who help you**.

**I hereby certify that the information provided is true and correct to the best of my knowledge and belief. This information will be used solely for purpose of qualifying and referring the above named individual for enrollment in Cumberland HealthNET.**

**Client Signature:**_____ **Date:** _____

**Employee Signature:**

_____

Employee Typed Name Title

_____

Employee Signature Date