Stehouwer Free Clinic

Eligibility Information

803 Lynn Street • Cadillac MI 49601 • 231-876-6150

First Name:_____ MI:____ Last Name:_____

Date of Birth: _____/_____/_____ Male _____ Female_____ Social Security Number_____-_____-_____

Address:_____ City:_____ Zip:_____

County: _____ Email:_____

Home Phone:_____ Cellphone:_____

Employer: _____ Temp Agency_____

Employment Status: Full-time Part-time Seasonal Self-Employed Unemployed Retired Disabled

Number of people in household: Adults (18 & over)_____ Children:_____

Marital Status: Single Married Divorced Widowed Partner

Housing: Own Rent Stay with friend/family Shelter

United States Veteran: Yes_____ No_____ **Citizen of United States:** Yes_____ No_____

Race/Ethnicity: White Black Hispanic/Latino Asian/Pacific Islander Native American Other

Primary Language: English Spanish Other Interpreter Needed Yes_____ No_____

Highest Education Level: _____

How did you hear about the Stehouwer Free Clinic?_____

Who is your Primary Care Provider?_____ Why aren't you seeing them today?_____

Health insurance coverage: Yes_____ No_____ Date of last medical exam/treatment:_____

Number of times have you been in the Emergency Room in the last year? _____

Emergency Contact Person: _____ Relationship:_____

Emergency Contact Phone Number: _____

I also understand it is my responsibility to inform staff of any changes. I authorize the Stehouwer Free Clinic to process my Eligibility Information and to share this information with charitable organizations to determine benefits.

Patient Signature: **Date:** **Screener Signature:** **Date:**

1._____ **1._____**

MUNSON HEALTHCARE
Cadillac Hospital

Financial Assistance Questionnaire

This is not an application for Medicaid. This form is used to see if you may be eligible for Medicaid or the hospital's financial assistance program.

Name: _____ **Date of Birth:** _____

Phone Number: _____

Please answer the following questions:

1. Are you a U.S. Citizen? ☐ Yes ☐ No

2. Do you have any religious affiliations that prohibit you from receiving benefits or do you file a tax exempt form 4029? ☐ Yes ☐ No

3. Are you under 21 years of age? ☐ Yes ☐ No

4. Are you pregnant? ☐ Yes ☐ No

5. Do you have any of your dependent children living with you that are under 18 years of age? ☐ Yes ☐ No

6. Are you receiving Social Security Disability payments? ☐ Yes ☐ No

7. Are you legally blind? ☐ Yes ☐ No

8. Are you disabled and unable to work? ☐ Yes ☐ No

9. Are you between the ages of 21-64 and at or below the following income levels? ☐ Yes ☐ No

Household Size	Yearly Income at or Below
1 person	$16,394
2 persons	$22,107
3 persons	$27,820
4 persons	$33,534
5 persons	$39,247

Healthy Michigan Program

10. Is your yearly income at or below the following? ☐ Yes ☐ No

Household Size	Yearly Income at or Below
1 person	$47,520
2 persons	$64,080
3 persons	$80,640
4 persons	$97,200
5 persons	$113,760

Hospital Assistance

If you answered Yes to any of the questions #3-9, you may be eligible to receive Medicaid through the State of Michigan. Please sign and return this form to the registration/check-in desk. You still have the right to apply for Medicaid if you believe you are eligible. Please contact your local Department of Human Services (DHS) or apply online at www.michigan.gov/mibridges.

Patient Signature: _____ **Date:** _____

Given to Patient:
#3-9 All No - Pink - Financial Assistance Packet with PLS (Tcodes 8917, 8354)
#3-9 Any Yes - Yellow - Medicaid Packet with PLS (Tcodes 9814, 8354)
No Application Given - only PLS offered (Tcodes 9733, 8354)
Comments: _____

Name (First, Middle Initial, Last): _____ Date of Birth: ____/____/____

Medical History (Check all that apply):

AIDS/HIV		Diverticulosis		Nervousness	
Alcoholism		Dizziness/Fainting		Numbness/Tingling	
Allergies		Hearing Aids		Osteoarthritis	
Anemia		Eye Disease		Osteoporosis	
Anxiety		Glasses/Contacts		Polio	
Arthritis		Frequent Infections		Peptic Ulcer Disease	
Asthma/Wheezing		Gallbladder Disease		Pneumonia (chronic)	
Bowel Irregularity		Gout		Rashes	
Bronchitis/Chronic Cough		Headaches (chronic)		Recovering Addict	
Bruise Easily		Heartburn		Rheumatic Fever	
Cancer		Heart Disease		Scarlet Fever	
Chronic Pain		Hepatitis B		Seizure Disclosure	
COPD		Hepatitis C		Sexually Transmitted Disease	
Crohn's Disease/Colitis		Hernia		Stomach Ulcer	
Coronary Artery Disease		Herpes		Strokes/TIA	
Dental Problems		High Blood Pressure		Thyroid Disease	
Depression		High Cholesterol		Vein Disease	
Diabetes—Type 1		Kidney Stones		Weight Gain or Loss (recent)	
Diabetes—Type 2		Mental Illness		Tobacco Use	
Difficulty Swallowing		Migraine Headaches		Other:_____	

Do you have concerns about your general health? Yes_____ No_____ **If yes, please share concerns**:_____

_____

Women: Are you Pregnant? Yes ___ No ___ **Last Pap Smear**: _____ **Last Mammogram**: _____

Do you have allergies? Yes_____ No_____ **If yes, please list all allergies: _____**

_____

Please list all prescription and over-the-counter medications you take: _____

_____

Past Surgeries _____

_____

Patient Signature: **Date:** **Screener:** **Date:**

1._____ 1. _____