Free Clinic of Pulaski County, Inc.
Eligibility Record

Patient's Name _____
Last First MI

Address _____ Phone (____) _____
Street or P.O. Box State one: home office other

_____ SS# ____ - ____ - ____
City, State, ZIP

Date of Birth (mm/dd/yyyy) ____/____/____ Age _____

If minor, parent/guardian name _____

Address/phone if different _____

Employed? No___ Yes___ Full Time___ Part Time ___

Employer _____

Number in family (inc. self, spouse, minor dependents) Adults ____ Children _____ Total _____

Family Income (includes wages, salary, tips, unemployment comp, social security, pension, alimony, child support) (**NOT** included, food stamps, WIC, fuel/housing assistance, earnings of minor child)

Name of Recipient	Source of Income	Amount	Frequency

Documentation (current food stamps acceptable) _____

Gross family income $_____ Allowable family income (from table) $_____

Does patient have: Medicare ___, Medicaid ___, Other Insurance ___, No Insurance ___

Special circumstances_____

Eligibility: _____ FULL (within allowable income and none of the above insurance programs)
_____ Pharmacy only (within income and eligibility)
_____ Not eligible (over income or has medicare or insurance)

Screener _____ Date ____/____/____

Notes/Follow up _____

PFC 11/10/2005