Florida Department of Health
in Sarasota County

CLIENT ELIGIBILITY REGISTRATION FORM

Name _____

Date of Birth_____ SS# _____ Sex ☐ F ☐ M Alien # _____

Hispanic ☐ Yes ☐ No Race_____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Living Address_____

Mailing Address_____

Home Phone _____ Cell Phone _____ E-mail Address _____

Please list everyone living in the home

Name	Date of birth	SS#	Relationship

Please list everyone in the home with any type of income including:

Earnings from employers, self-employment, unemployment, worker's compensation, social security, death benefit, pensions, alimony, child support, public assistance, veterans benefits, investments, trust funds, rental income, student disbursement of financial aid, loans, grants, assistance from others, odd jobs, scrapping metal, selling personal items, cash withdrawn from any banks or other sources.

Name	Employer or type of income	Monthly gross income

Please answer the following questions:

What brings you here today? _____

Do you know that the Florida Department of Health in Sarasota County offers Primary Care Services? ☐ Yes ☐ No

Have you been hospitalized in the last 30 days? ☐ Yes ☐ No Which hospital? _____

Does any family member have Medicare coverage? ☐ Yes ☐ No Medicare Part D? ☐ Yes ☐ No

Does any family member have Medicaid coverage? ☐ Yes ☐ No Have you applied for Medicaid? ☐ Yes ☐ No

Do you have any medical coverage/private health insurance? ☐ Yes ☐ No Plan Name _____

Are you pregnant, a new mother, or received a pregnancy related service in the past 2 years? ☐ Yes ☐ No

Are you paying child care? ☐ Yes ☐ No If yes, how much and where to? _____

Do you have a court order to pay child support for a child not in your home ☐ Yes ☐ No

Do you have children under age 21 in your home? ☐ Yes ☐ No Relationship to children _____

Are you homeless or living temporarily with others? ☐ Yes ☐ No

Are you a veteran? ☐ Yes ☐ No Are you disabled? ☐ Yes ☐ No Are you over 55 years of age? ☐ Yes ☐ No

I affirm that the information that I am providing is true and correct. I understand that if I provide false or inaccurate information that services may be discontinued and I will have to pay for all services received according to the fee schedule. FAC64f10.003(5).

Signature _____ Date _____

Revised 07/22/2014