

**Community Health Clinic of Butler County**

**Telephone Eligibility Screening Form**

103 Bonnie Dr., Butler, PA 16002

Phone: 724-841-0980 Fax: 724-841-0984 Website: www.butlerhealthclinic.org

**Date:** \_\_\_\_\_

<b>Person applying for Clinic Services:</b>	Last Name: _____	First Name: _____
Address _____	City _____	Zip _____
Birthdate - (mm/dd/yyyy) _____	Home Phone: _____	Cell Phone: _____
May we contact you at either phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No    May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been served by this clinic before? <input type="checkbox"/> Yes <input type="checkbox"/> No How can we help you at this time? <input type="checkbox"/> Medical <input type="checkbox"/> Dental    Problem/Specific Symptoms: _____ _____		
Are you in need of any mental health medications?    Yes    No		Are you currently receiving care from a mental health agency? Yes    No    Agency: _____

**We first need to determine if you are eligible for our services by asking these questions:**

Are you a Butler County resident?  Yes  No

What is your gross income (*before taxes*)? \_\_\_\_\_  Weekly  Monthly  Yearly  Other (*Specify*) \_\_\_\_\_

Details: \_\_\_\_\_

Do you have any health insurance?  Medical  Dental  None

Medicare Part A     Medical Part B     Medicaid/Medical Access Card     Veterans Benefits     CHIP     AdultBasic

Details: \_\_\_\_\_

*(If a person only has hospitalization and NO primary care coverage, they are eligible provided they are financially eligible.)*

Have you applied for Medical Assistance? (Yes / No) \_\_\_\_\_    If yes, how long ago? \_\_\_\_\_

Reason for denial: \_\_\_\_\_

How many people did you claim on your current tax return?\*(spouse, children, etc) \_\_\_\_\_

# of people in household \_\_\_\_\_

Employer: \_\_\_\_\_ (Self Employed, Seeking Employment, Unemployed)

<b>INCOME GUIDELINES (200% of 2009 Federal Poverty Guidelines):</b>			
<b>Number in Household</b>	<b>Weekly Income</b>	<b>Monthly Income</b>	<b>Yearly Income</b>
1	\$417	\$1,805	\$21,660
2	\$560	\$2,428	\$29,140
3	\$704	\$3,052	\$36,620
4	\$848	\$3,675	\$44,100
5	\$992	\$4,298	\$51,580
6	\$1,136	\$4,922	\$59,060
7	\$1,280	\$5,545	\$66,540
8	\$1,423	\$6,168	\$74,020
Add for each additional member:	\$144	\$623	\$7,480

**Preliminary Eligibility Determination:**

Eligible  Yes  No    Comments: \_\_\_\_\_

If eligible, schedule an eligibility appointment and tell patient to bring all of the following with them to the appointment: **W2 form, most recent federal tax return, 30 days worth of pay stubs, proof of address (utility bill, rent receipt or driver's license), and (if applicable) medical assistance denial letter.**

Patient's Scheduled Eligibility Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Letter Sent Date:** \_\_\_\_\_