2224 N Kate Ave STE 100,
Oklahoma City, OK 73111
(405) 254-8233
clarahealthcenter@gmail.com

CCHC

Clinic Patient Verification Form

SECTION 1: PATIENT CONTACT INFORMATION

Name: Last _____ First _____ Middle_____

Social Security Number: _____

Address: _____ city _____- State _____ zip code

Date of Birth _____ Telephone Number_____

Sex: ◯ Male ◯ Female Ethnicity: ◯ Hispanic ◯ Non-Hispanic

Race: ◯ White ◯ African American ◯ Asian ◯ American Indian

SECTION 2: PATIENT ACKNOWLEDGEMENT - FINANCIAL ELIGIBILITY

Do you have Insurance that covers ? ◯ Health ◯ Vision ◯ Dental ◯ No Insurance

Do you currently have Medicare ? ◯ Yes ◯ No

Do you currently have MEDICAID ? ◯ Yes ◯ No

Do you have any PRIVATE Insurance ? ◯ Yes ◯ No

Are you US citizen ? ◯ Yes ◯ No

Are you resident of Oklahoma State ? ◯ Yes ◯ No

House hold size: _____

Please provide Gross MONTHLY earned and unearned TOTAL INCOME:_____

Does your income meet following Criteria: ◯ Yes ◯ No

HOUSEHOLD SIZE	NET MONTHLY INCOME (130% of Poverty)
1	$ 1,776
2	$ 2,226
3	$ 2,677
4	$ 3,128

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5	$ 3,578
6	$ 4,029
7	$ 4,480

Each Additional Member : Add $ 347

A family's gross monthly income is determined from the heads of the household's adjusted gross income tax returns or an certified letter. Monthly assistance for food, housing, utilities, alimony, and any other earnings or assistance not reflected upon the tax return/stipend letter should be added in to determine the gross monthly income.

SECTION 3: PATIENT REFERRAL

NOTICE TO PATIENT: You are being referred to a Volunteer health care provider, who will provide care to you or to someone for whom you are legally responsible. Your participation in this referral process is voluntary. The care you receive from the Volunteer Health Care Professional will be provided at NO CHARGE to you.

PATIENT ACKNOWLEDGEMENT: The information I have provided regarding my eligibility, income information, insurance information, is true and complete to the best of my knowledge. My signature confirms that I meet above criteria and agree to provide copy of last year tax return or other financial documentation, if it is required. I also acknowledge that failure to provide the CLINIC with an update on financial or health insurance status, may result in disqualification to receive health care under CLINIC OKC. I further understand that falsification of any information mentioned in this form constitutes automatic disqualification from CLINIC OKC.

I certify that, I DO NOT have Medicare, Medicaid or Private insurance.

Signature of Patient / Parent / Guardian: _____

Printed Name of Person Signing: _____

Date: _____