LIGHT OF THE WORLD CLINIC

Free medical care

Atención médica gratuita

- ☑ Live in Broward/Vivir en Broward
- ☑ Low Income/Bajos Ingresos
- ☑ Uninsured/Sin Seguro medico

Contact: Patient Eligibility Coordinator, Susana Nusser

Phone: (954) 563-9876 ext. 206 Fax: (954) 563-3670

5333 N. Dixie Highway #201 Oakland Park, FL 33334

Email: susana@lightoftheworldclinic.org

(Revised July, 2019)

WHAT YOU WILL NEED:

Applicants must provide the following documents with their application for consideration and final approval.

1. **COPIES of 2 forms of photo identification**- ONE with your current address for each person applying
    a. COPY of Birth Certificate and School ID for each minor child under 21 living at home

2. **Proof of domicile requirements:** Please supply ONE of the following documents.
    a. **COPY** of current lease agreement/contract along with a copy of the last rent payment receipt. OR
    b. **COPY** of last paid mortgage statement. OR
    c. If you don't have a rental agreement or own a home - then you MUST submit a "*Rent Verification Form*" or an **ORIGINAL** notarized letter from Landlord with details of your current living arrangement:
        - Monthly rental amount
        - Complete address with city and zip code
        - Are utilities included?
        - Length or terms of living arrangement (monthly, yearly)
3. **Proof of Income requirements:** Please supply any of the following documents that apply to your family situation.
    a. **COPIES** of the last 6 weeks consecutive paystubs for ALL adults in the family.
    b. If your employer pays you in cash you MUST submit an **ORIGINAL** notarized letter verifying employment.
    c. If you are self-employed, you MUST submit an **ORIGINAL** notarized letter stating your occupation and monthly income.
    d. If you don't work, you MUST still submit an **ORIGINAL** notarized letter stating that you have no income and explain why.
4. **COPY of your CURRENT BILLS**: FPL, Phone or other Utility Bill you have in your name.
5. **COPY of your most recent tax return** (ALL PAGES) including W2/1099 if you filed one.
6. **COPY of ALL car registrations** for the household in your name.

LO QUE NECESITARÁS:

Aplicantes deben presentar los siguientes requisitos, los cuales serán revisados por la clínica para aprobación final.

1. **COPIAS de 2 formas de identificación** – UNA con la dirección corriente para cada persona que esta aplicando.
    a. COPIA del Acto de Nacimiento e Identificación de la Escuela/Universidad para cada menor de 21 años de edad, que vive en el hogar

2. **Prueba de vivienda o domicilio:** Presente UNO de los siguientes documentos.
    a. **COPIA** del contrato de alquiler con copia del último recibo de pago de renta.
    b. **COPIA** de la hipoteca y copia del último recibo de pago de hipoteca/"mortgage".
    c. Si no tiene contrato de alquiler o propiedad -puede someter una "*Verificacion de Renta*" o una carta notariada (**ORIGINAL)** por el dueño del hogar describiendo los detalles de la vivienda. La carta tiene que incluir:
        - Cuánto pagan mensual de renta?
        - La dirección completa
        - Incluye luz, agua, cable, internet?
        - Fecha cuando se termina el contrato.
3. **Prueba de ingreso**: Presente cualquier documento siguiente que le aplique a usted y su pareja para cumplir con este requisito.
    a. **COPIA** de los últimos desprendibles del cheque de pago de las últimas 6 semanas para todos los adultos en el hogar.
    b. Si le pagan en efectivo o trabaja por sí mismo, necesita una carta notariada (**ORIGINAL**) verificando empleo y detallando su tipo de trabajo e ingreso mensual.
    c. Si usted o su pareja no trabajan, necesitan una carta notariada (**ORIGINAL**) donde declaran que no trabajan y que no tienen ingreso.
4. **COPIAS de CUENTAS MAS RECIENTE**: Luz, Agua, Telefono o otra cuenta en su nombre.
5. **COPIA de la Declaración de impuestos** más reciente si han declarado con W2/1099(TODAS LAS PAGINAS).
6. **COPIA de la registración de TODOS los vehículos** en el hogar que están en su nombre.

Light of the World Clinic / Clinica Luz Del Mundo

5333 N. Dixie Hwy #201, Oakland Park, FL 33334 Ph: 954-563-9876

www.LightoftheWorldClinic.org www.ClinicaLuzDelMundo.com

Today's Date: _____ **Referred By:** _____

Do you have health or dental insurance for you or anyone in your family? NO ☐ YES ☐
(If yes, who is covered? Person insured is NOT eligible for the clinic services) _____

Name of Applicant: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: _____
(STREET) (CITY/STATE) (ZIP CODE)

Date of Birth: _____ **SS# or TIN#:** _____ **Male ☐ Female☐**

Telephone #1_____ **#2**_____ **Email:** _____
(Home) (Mobile)

Race: (Must Choose an Answer) White ☐ Black ☐ Asian ☐ American Indian ☐ Pacific Islander ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐ **Do you file a yearly tax return? No ☐ Yes ☐**
(Please attach a copy of your most recent tax return)

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living Together ☐

Are you a Veteran? Yes ☐ No ☐ Number in household who have served in the US Armed Forces_____

Emergency Contact information: _____
(Name) (Relationship) (Telephone)

If you receive benefits from the following agencies, place an "X" in the box next to the agency.

Medicaid ☐ Medicare ☐ Medical Disability ☐ Workman's Comp ☐ ACA-Obamacare ☐ Other Clinic/Medical Office ☐

Please check the following: New Application ☐ OR Renewal Application ☐
Is this application for: Individual ☐ OR Family of_____
(If this is a family application, please list each uninsured family member that you wish to include on this application and include their Name, DOB and Occupation in the space below.)

	NAME	DOB	OCCUPATION
APPLICANT / SELF			
SPOUSE			
CHILD #1			
CHILD #2			
CHILD #3			

Please take a moment to review and initial the following statements to show you understand these policies.

1. I certify by my initials & signature below that, to the best of my knowledge, the information in this application is a true and complete statement. I understand that the information I have given is subject to verification by the clinic eligibility coordinator. _____**(initial)**
2. I acknowledge that I am responsible for informing the clinic of any changes in my housing, marital status, work, financial and health insurance status prior to my next visit. _____**(initial)**
3. I also acknowledge that once I and/or my family are approved for the clinic's medical services, we each have 90 days to make an appointment for a complete physical; otherwise, risk losing the clinic's services. _____**(initial)**

X_____ _____
SIGNATURE OF PATIENT/PARENT OR GUARDIAN **DATE**

Office Use Only: Code/Approval date: _____ _____
Clinic Eligibility Coordinator

Expiration date: _____

Emergency Room & Hospital History: (To be completed by Head of Household requesting clinic services)

NOTE: If you have been to the ER or hospital in the last year, and you can find your discharge papers from that visit, **please bring them to your first appointment**. That will help your nurse and doctor understand what happened at the ER and give you better care.

ER History within the past year

In the last year, have you been to a hospital's Emergency Room (ER)?

○ No ○ Yes If yes, please fill out the information below:

Approx date of visit (only list those within the last year)	Hospital	Reason you went to the ER (chief complaint)

If you went to the ER more than 4 times in the last year, write the additional dates here:

Hospital History within the past year

In the last year, have you been admitted to a hospital?

○ No ○ Yes If yes, please fill out the information below:

Approx date (only list those within the last year)	Hospital	Reason for hospitalization

If you were hospitalized more than 4 times in the last year, write the additional dates here:

Signature: I certify by my signature that, to the best of my knowledge, the information entered in this Eligibility Form and Health Summary Form is true and complete. I further understand that failure to provide accurate information may result in discharge from Light of the World Clinic (LOTWC).

_____ X _____ _____

Patient Name Patient Signature Date

I, hereby, consent to the release of my demographic information only (name, address, social security number, and date of birth) to Broward Health, Holy Cross Hospital and/or _____, and they may release information to LOTWC on services provided, for the purpose of tracking whether cost savings have been achieved through primary care services offered at LOTWC.

_____ X _____ _____

Patient Name Patient Signature Date

VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM

CLINIC/PROGRAM/PROVIDER: Light of the World Clinic, Inc.

Section 1

Does the client/patient have insurance that covers the health or dental condition? YES _____NO _____

Does anyone in the client/patient's family have an active FL Medicaid card? YES ____ NO ____

Name of the card holder and Medicaid No. _____

Client/Patient/Head of Household's Name: _____

(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: _____

(STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: _____ Name of Contact: _____

Section 2

Family Size: Adults____ Under 18 ____ 18-21--Student ____ Unborn _____ Family Size TOTAL _____

FAMILY MEMBERS NAME (First and Last)	**DOB**	**EMPLOYER**	**GROSS EARNED INCOME LAST 4 WKS**	**GROSS UNEARNED INCOME LAST 4 WKS** (Do not include TCA or SSI)
SELF			**$**	**$**
SPOUSE/PARTNER			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
CHILD			**$**	**$**
		TOTALS	**$**	**$**
		Add earned and unearned income to determine total		**TOTAL INCOME $_____**

Section 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)

Step 1. **"TOTAL FAMILY INCOME"** for family unit (Earned and unearned income). (1) $_____ (Above)

Step 2. Subtract $90 for EACH employed member of the family unit. (2) $_____ (Minus)

(2a) $_____ (Total)

Step 3. Subtract childcare PAID each month (up to $175 per child age 2 and older; up to $200 per child under age 2). (3) $_____ (Minus)

(3a) $_____ (Total)

Step 4. Subtract up to $50 per month of total child support received. (4) $_____ (Minus)

Step 5. **TOTAL NET INCOME** (5) $_____ (Total)

Section 4 USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit. I acknowledge receipt of the Department of Health's Notice of Privacy Practices.

_____ _____

SIGNATURE OF CLIENT/PATIENT/PARENT OR GUARDIAN AND DATE

PRINT NAME OF DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE

(VALID FOR ONE YEAR) Expiration date: _____

DH 1032E (12/14), 64I-2.002(4), F.A.C.