

**VOLUNTEERS IN MEDICINE of SOUTHERN NEVADA**

4770 Harrison Drive, Las Vegas, NV 89121 Phone: 702-967-0530 Fax: 702-967-0538

**Eligibility Screening Form**

Web site: www.vmsn.org

PERSON APPLYING FOR CLINIC SERVICES:

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ DOB: \_\_\_\_\_

May we contact you at either number? \_\_\_ Yes \_\_\_ No May we leave a message? \_\_\_ Yes \_\_\_ No

Have you been served by this clinic before? \_\_\_ Yes \_\_\_ No If Yes, When: \_\_\_\_\_

How may we help you at this time? \_\_\_ Medical \_\_\_ Other: explain \_\_\_\_\_

ELIGIBILITY CRITERIA

Are you a CLARK COUNTY resident for a minimum of 3 months? \_\_\_ Yes \_\_\_ No

Are you a U.S. Citizen or legal resident? \_\_\_ Yes \_\_\_ No

What is your GROSS INCOME before taxes? \_\_\_\_\_ Wkly \_\_\_ Monthly \_\_\_ Yrly \_\_\_ other: *specify* \_\_\_\_\_

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

How many people did you claim on your current tax return? (Spouse, children, etc) \_\_\_\_\_ # of people in Household? \_\_\_\_\_

Do you have HEALTH INSURANCE? \_\_\_ Medical \_\_\_ Dental \_\_\_ None

Medicare Part A \_\_\_ Medicare Part B \_\_\_ Medicaid \_\_\_ CHIP \_\_\_ Veterans Benefits \_\_\_ Other: \_\_\_\_\_

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

\*If a person only has Hospitalization and NO primary care coverage, they are eligible provided that they meet financial eligibility.

Have you applied for Medical Assistance? \_\_\_ Yes \_\_\_ No If YES, how long ago? \_\_\_\_\_

Reason for Denial? \_\_\_\_\_

Employer: \_\_\_\_\_ Self employed \_\_\_\_\_ Unemployed \_\_\_\_\_

**INCOME GUIDELINES (200% Federal Poverty Guidelines/2009):**

<u>Number in Household</u>	<u>Weekly Income</u>	<u>Monthly Income</u>	<u>Yearly Income</u>
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 inform of required documents.

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

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Letter sent/date: \_\_\_\_\_