ROCK RIVER Free Clinic
1541 Annex Road, Jefferson, WI 53549
Phone: 920-674-7442 ❖ Fax: 920-674-7460

PATIENT APPLICATION

TODAY'S DATE:

PATIENT INFORMATION

First Name: | Middle Initial: | Last Name:

Date of Birth: (month/day/year) | Sex: ☐ Male ☐ Female | Social Security Number: (or ITIN)

Street Address:

City: | State: | Zip Code: | County:

Home Phone | Cell Phone | Other Phone: (Please specify whose phone it is)

OTHER INFORMATION

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Ethnic Racial Background:

☐ American Indian or Alaska Native ☐ Black/African American ☐ Asian

☐ Hispanic/Latino ☐ Hawaiian or Pacific Islander Native ☐ White ☐ Unknown

Education Level: (Please check box for highest level completed)

☐ Elementary - Finished ☐ Middle School - Finished ☐ High School graduate

☐ GED/HSED ☐ College - Some ☐ College graduate

☐ Post graduate ☐ Other, (please explain):

Referral Source:

☐ Friend/Family ☐ Fort HealthCare Emergency Department

☐ Social Service Agency ☐ Fort HealthCare Hospital

☐ Employer ☐ Fort HealthCare Provider

☐ Website: (please list website)

☐ Other: (please explain)

Housing:

☐ Own ☐ Rent ☐ Trailer/Lot Rent ☐ Shelter ☐ Friend/Family ☐ None

☐ Other: (please explain)

EMERGENCY CONTACT

Name (First, Last) | Phone #

Address: (Street Address, City , State and Zip Code)

Relationship to patient:

DEPENDENTS

ALL HOUSEHOLD MEMBERS – Head of Household legally financially supports (example: claimed on tax return)

	Name	Relationship to Patient	Age
1.			
2.			
3.			
4.			
5.			
6.			

INSURANCE INFORMATION

Do you have **any** form of health insurance? ☐ **Yes** (If yes, check appropriate box below) ☐ **No**

☐ Badgercare (Medical Assistance) ☐ ☐

☐ Veteran ☐ ☐

☐ Other, (please explain) _____

Do you currently have access to insurance through your employer? ☐ Yes ☐ No

Are you currently denied access to health care because you are unable to pay? ☐ Yes ☐ No

Have you applied for insurance through Healthcare.gov (MarketPlace)? ☐ Yes ☐ No

If Yes, ☐ Eligible ☐ Eligible but unable to afford ☐ Ineligible ☐ Unsure

Have you applied for Badgercare? ☐ Yes ☐ No

If Yes, ☐ Eligible ☐ Ineligible ☐ Unsure

INCOME INFORMATION

Patient Employment Status:

☐ full-time ☐ part-time ☐ seasonal ☐ unemployed

☐ not in labor force ☐ retired ☐ self-employed

Employer: _____ Address of Employer: _____

Spouse Employment Status:

☐ full-time ☐ part-time ☐ seasonal ☐ unemployed

☐ not in labor force ☐ retired ☐ self-employed

Employer: _____ Address of Employer: _____

Income Sources - Gross monthly income (BEFORE TAXES):	**GROSS MONTHLY**
Wages – patient	
Wages - spouse	
Wages – Other (describe):	
Unemployment	
Social Security	
Pension	
Disability	
Other (please explain):	
Gross (BEFORE TAXES) Monthly Household Income (from all sources)	

HOLD HARMLESS: I agree to release and hold harmless Rock River Free Clinic, its Board of Directors, all volunteers, physicians, nurses and other workers from any claims or demands arising from the care of services I receive.

CONSENT TO TREAT: I give permission for treatment and evaluation by the medical personnel at the Rock River Free Clinic.

CERTIFICATION STATEMENT: I certify that the above information provided is true and complete to the best of my knowledge and belief. I hereby authorize release of medical or financial information to (or by) the Rock River Free Clinic necessary for verification of eligibility and coordinating my care under its programs.

_____ _____

Signature of Applicant **Date**

Screening Date: _____

Screeners Initials: _____

- STAFF USE ONLY- -

INFORMATION CHANGE ENTERED IN COMPUTER

Staff Initials	Date	Staff Initials	Date	Staff Initials	Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____