Christian Medical Clinic of Grand Lake Inc.
PO Box 451368 Grove OK 74345-1368
Tel/Fax 918-787-5191 cmc_grove@swbell.net

Eligibility Application

Date: _____ Name: _____ _____ _____
First MI Last

Mailing Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell: _____ Marital Status: S M W D

Soc. Sec. No: _____-_____-_____ Birthdate: ___/___/_____ Age: _____

Head of household? Yes No **Number in household: _____ Ages: _____**

Home Status: Own____Rent____Hotel____Family____Homeless___Other_____

Monthly Income: SSA_____SSI_____VA_____State_____Child support_____

Salary/Wages/Commissions _____ Employer: _____

Other income: _____ _____ _____ _____
Amount Source Amount Source

Do you have the following: Medicare_____ Medicaid _____ CDIB _____ VA _____
Health Ins._____ Prescription Coverage_____Other _____

Do you have reliable transportation: Yes No **County of Residence**: _____

Emergency/Alternate Contact: _____
Name Relationship Phone#

I understand the purpose of this clinic is to provide medical care to those who have no insurance, including Medicare or Medicaid, and who are unable to afford adequate medical care. I agree to provide proof of income (i.e. copy of most recent tax returns and/or two months pay stubs). I understand the professional services are provided by volunteers and I agree to hold harmless the facility and volunteers for the services I may be provided. I have read and understand the New Patient Information form and agree to fulfill my responsibilities as outlined in that document. I certify that the above information I have provided is true and complete to the best of my knowledge.

I understand that effective November 1, 2011, a secure electronic patient database was implemented. My demographic information as well my clinical information is stored in this web-based database. Identifiable information from this database will be disclosed only when necessary for continuity of care. Unidentifiable information may be shared in the aggregate in such things as statistical reports, grant requests, or other uses which do not identify you by name or other identifier. I agree to this use of the electronic database.

Signed:_____ Date:_____

For office use only:

Identity verified: _____

Application approved: _____

Application denied: _____ Reason: _____

Other healthcare/income options discussed: _____

Signed: _____