



Walton County Health Department and Walton Community Health Center
FINANCIAL ELIGIBILITY FORM

Patient Name (Last Name) (First Name) (Middle Initial)

AKA

Physical Address City State Zip

Mailing Address City State Zip

Telephone Number

Date of Birth: Sex: Male Female Social Security #

What is your language preference?

Do you need an interpreter: Yes No?

Marital Status: (check one) Married Single Separated Divorced Unknown

Were you a single or twin at birth? if twin, what was your order: 1st, 2nd, 3rd

Choose one of the following: Heterosexual/Non-Heterosexual Straight Gay Lesbian Homosexual

Transgender: (check one) Yes No Sex at Birth: Male Female

Ethnicity (check one): Non-Hispanic/Latino Hispanic/Latino Race:

Country of Birth: Are you a migrant: (check one) Yes No

Date you arrived in the United States: Year Are you a seasonal agricultural worker: Yes No

Highest level of education: Are you a veteran of the US Services? Yes No

LIVING QUARTERS: (please check)

Do you? Rent Own Lives with family/friends Homeless Other Housing Arrangements unstable

How many rooms in total do you have where you currently live?

What method(s) do you use to heat and cool your home with?

Check the working items you have: Refrigerator Cooking Stove Hot plate Fan Indoor toilet Water inside for drinking Water inside for bathing

The Walton Community Health Center does not deny anyone services because of race, national origin, skin color, religion, sexual orientation, physical handicap, disability, source of payment, or the inability to pay and uses recent Federal Poverty Guidelines to establish a sliding fee scale for eligible low-income patients. If you would like to apply for our Sliding Fee Scale please complete the section below.

Person responsible for payment _____
 (Last Name) (First Name) (Middle Name)
 DOB _____ Soc. Sec. # _____
 Address if different from patient _____

Do you have insurance that covers your health or dental condition? YES NO
 Name of Insurance Co. _____ Policy No. _____ Group No. _____
 Name of the card holder (Insured) _____

I understand that I will be assigned to the full fee category and that I am responsible for any charges denied or not paid by my insurance.
 I also authorize the payment of medical benefits to the Walton County Health Department. Payment is due at the time services are rendered, unless prior arrangements have been made. Past due accounts may be referred to a collection agency.

 SIGNATURE OF CLIENT/PARENT or GUARDIAN SIGNATURE OF DEPARTMENT OF HEALTH EMPLOYEE DATE

INCOME FOR YOUR COMPLETE HOUSEHOLD OR FAMILY UNIT
 List each family member in household and include ALL types of income.

NAME	Date of Birth	FAMILY RELATIONSHIP	Place of Employment or Other Source of Income	Income before Taxes or Deductions.
1.		Patient		\$ WK BW MO
2.				\$ WK BW MO
3.				\$ WK BW MO
4.				\$ WK BW MO
5.				\$ WK BW MO
6.				\$ WK BW MO
7.				\$ WK BW MO
8.				\$ WK BW MO

DO YOU PAY CHILD SUPPORT? YES / NO
 HOW MUCH A MONTH?
 \$ _____

DO YOU PAY FOR CHILD CARE? YES / NO
 HOW MUCH A MONTH? \$ _____

I was provided a copy of the Primary Care//Family Planning Services Information sheet on _____.
 Patient initials _____

Interview Clerk initials _____

