COOPER GREEN MERCY HEALTH SERVICES AUTHORITY
Jefferson County Outpatient Care
HEALTH FIRST PROGRAM APPLICATION
THIS CHARITY DISCOUNT PROGRAM IS NOT AN INSURANCE PLAN. MEDICAL SERVICES ARE FOR JEFFERSON COUNTY RESIDENTS ONLY.

This Section for Clinic Use Only: DATE: _____ ARRIVAL TIME: _____ MRN: _____

Scheduled Appt ☐ Walk-in ☐ Re-Enrollment ☐ New Enrollment ☐

County Resident (please check one): Yes ☐ No ☐

Enrollment Specialist: _____ Time Began: _____ Time Ended: _____

Patient's Name (Last, First, MI): _____

Patient's Phone Number: _____ ☐ Home ☐ Cell **E-Mail Address:** _____

Address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: ____/____/____ **Age:** _____

Social Security #: _____

Birth Gender (please check one): ☐ Male ☐ Female

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

Preferred Pharmacy: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone #: _____

Employment Status: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed ☐ Self-employed ☐ Odd Jobs

Receive any unearned income (please check all that apply):

☐ SSI ☐ SSA ☐ VA Benefits ☐ TANF ☐ Child support ☐ Alimony ☐ Contribution income from family and/or friends ☐ Other

Patient's Employer: _____

Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone #: _____

Does your employer offer insurance? Yes ☐ No ☐
Insurance Name _____
Policy Number _____

Please list information concerning spouse and/or dependent children. If you are a dependent, list parents or guardians.

Name: **Relationship:** **Age:** **Employed: Yes ☐ No ☐**

I hereby give Cooper Green Mercy Health Services Authority (Jefferson Outpatient Care), permission to investigate any information provided, including but not limited to performing credit checks, contacting employer, and notifying references. I understand that if any false information is given, I will be fully responsible for all charges including court cost and attorney fees.

Patient's Signature: _____ **Date:** _____ (Revised October 2022)