Volunteers In Medicine
OF CAPE MAY COUNTY
Neighbors caring for neighbors

PATIENT APPLICATION

423 Route 9 North, CMCH, NJ 08210 / 3073 English Creek Ave, EHT, NJ 08234 / (609)463-2846 / info@vimcmc.org

New Patient please complete

☐ Cape May County: ☐ Atlantic County

Today's Date: Date of Birth: Preferred Language: ☐ English ☐ Spanish

Patient Information

Last Name: First Name: Middle Name:

Street Address: City: State: Zip:

Telephone — Primary: Secondary:

Emergency Contact: Name: Phone: Relationship

Demographics:

☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed ☐ Other
☐ African American ☐ Asian ☐ Hispanic
☐ Native American ☐ White ☐ Other

Are you? A Veteran? ☐ Yes ☐ No

Insurance: Do you have any of the following Health Insurance Plans:

☐ Medicaid * ☐ Medicare ☐ VA Benefits
☐ I am Uninsured ☐ Private Insurance

* Have you applied for NJ Family Care/Medicaid? ☐ Yes ☐ No If denied, why? _____

Employment:

☐ Full Time ☐ Part Time ☐ Seasonally
☐ Unemployed ☐ Retired ☐ Disabled

Employer: **Occupation:**

How many times have you been to the Emergency Room (ER) in the last three (3) years? _____

Other Household Members: # of Adults _____ # of children Under the age of 19__ _____

Name	M/F	Relationship	Date of Birth	Insured?
1				
2				
3				
4				

Intake

Reviewed Date: _____/_____/_____

Reviewed by Print Name: _____

Signature: _____

Patient's Income $_____/mo Patient's Income $ _____/yr

Patient ID#:

_____

Exp Date:

____/____/_____

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❖ **Photo ID (bring one)** ✔ Driver's License ✔ Passport/Visa ✔ Work ID

Additional documentation :

Are you working? ☐ **Yes** ☐ **No**

If Yes (bring one):
- ✔ 4 weeks of current paystubs
- ✔ Employer letter
- ✔ Self Employed: three (3) months of Bank Statements

If No:
- ✔ 1 Unemployment check
- ✔ Survival Letter

Do you receive: (check all that apply)

☐ Child Support ☐ Alimony ☐ SNAP ☐ Social Security Retirement

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4				

Intake

Reviewed Date: _____/_____/_____

Reviewed by Print Name: _____

Signature: _____

Patient's Income $_____/mo Patient's Income $ _____/yr

Patient ID#:

_____

Exp Date:

____/____/_____

Volunteers In Medicine
OF CAPE MAY COUNTY
Neighbors caring for neighbors

PATIENT DOCUMENTATION

423 Route 9 North, CMCH, NJ 08210 / 3073 English Creek Ave, EHT, NJ 08234 / (609)463-2846 / info@vimcmc.org

Please provide copies of following documents with your completed application. If you are married, you will also need to provide documents for your spouse's income.

Required Documentation:

❖ **Previous year's tax return (1040)**
(if you do not file taxes, please bring as many of the items listed below as you can)

❖ **Photo ID (bring one)** ✔ Driver's License ✔ Passport/Visa ✔ Work ID

Additional documentation :

Are you working? ☐ **Yes** ☐ **No**

If Yes (bring one):
- ✔ 4 weeks of current paystubs
- ✔ Employer letter
- ✔ Self Employed: three (3) months of Bank Statements

If No:
- ✔ 1 Unemployment check
- ✔ Survival Letter

Do you receive: (check all that apply)

☐ Child Support ☐ Alimony ☐ SNAP ☐ Social Security Retirement

☐ Social Security Disability ☐ Annuity Payments

Other documentation:

☐ NJFamilyCare (Medicaid) denial letter ☐ Veteran Benefit Denial Letter