St. Francis Medical Center

Health Benefits Resource Center
Application Screening Form

Applicant Information

Applicant Name: _____ ☐ M ☐ F
Address: _____
City: _____ State:_____ Zip:_____
Phone (Home): _____ Cell: _____ Work: _____
Email: _____
Date of Birth: _____ Place of Birth: _____ Social Security #:_____

Marital Status: ☐ Single ☐ Legally Married ☐ Legally Separated ☐ Divorced ☐ Widow

Currently Employed? ☐ Yes ☐ No Type of Work: _____

How Often Paid? ☐ Weekly ☐ Biweekly ☐ Monthly Pay Amount: _____ Pay Type: ☐ Cash ☐ Payroll

Date of Last Check Received: _____ Will Employment Continue? ☐ Yes ☐ No

Any Other Income? ☐ SSI ☐ Retirement ☐ Disability ☐ Other _____
How Much Received? _____ If no income, when was last employment? _____

Does anyone support you economically? ☐ Yes ☐ No
Name: _____ Relationship: _____

Your legal status: ☐ None ☐ Citizen ☐ Permanent Resident ☐ Naturalized Citizen ☐ Work Permit ☐ Student Visa

Date Entered US: _____ Do You File Taxes? ☐ Yes ☐ No ☐ Plan to File This Year: ☐ Yes ☐ No

Filing Status: _____ Last Filed: _____ File with ITN: ☐ Yes ☐ No

Spouse Information

Spouse/Partner Name: _____ ☐ M ☐ F

Spouse/Partner Place of Birth _____ Is Spouse/Partner Employed: ☐ Yes ☐ No

Type of Work _____ How Often Paid? ☐ Weekly ☐ Biweekly ☐ Monthly

Pay Amount: _____ Pay Type: ☐ Cash ☐ Payroll Date of Last Check Received: _____

Will Employment Continue? ☐ Yes ☐ No Any Other Income? ☐ SSI ☐ Retirement ☐ Disability ☐ Other:_____
How Much Received? _____ If no income, when was last employment? _____

Does anyone support you economically: ☐Yes ☐ No Name:_____ Relationship:_____

Spouse/Partner's Legal Status: ☐ None ☐Citizen ☐ Permanent Resident ☐ Naturalized Citizen ☐ Work Permit

☐ Student Visa Date Entered US: _____ Do Your Spouse/Partner File Taxes? ☐Yes ☐No

Plan To File This Year: ☐Yes ☐ No Filing Status: _____ Last Filed: _____ File with ITN? ☐Yes ☐ No

Any Children Under 21 Living at Home? ☐ Yes ☐No Do they have Medi-Cal? ☐ Yes ☐No
Name(s): _____
DOB: _____

Place of Birth: _____ Are They Tax Dependents? ☐ Yes ☐No

If Over 65

Do You Have Medicare? ☐ Yes ☐No Medicare Beneficiary Identifier (MBI): _____

If No, do have you applied or plan on applying? ☐ Yes ☐No

Any Properties? ☐ Yes ☐No Type: _____

Bank Accounts? ☐ Yes ☐No Type: ☐ Checking ☐ Savings ☐Business
Amount in Each Account: _____

Does Your Spouse/Partner Have Medicare? ☐ Yes ☐No Medicare Beneficiary Identifier (MBI): _____

If No, do have you applied or plan on applying? ☐ Yes ☐No

Any Properties? ☐ Yes ☐No Type: _____

Bank Accounts? ☐ Yes ☐No Type: ☐ Checking ☐ Savings ☐Business
Amount in Each Account: _____

If Homeless

Since When? _____ In What County: _____

Additional Questions

Any Military Service? ☐ Yes ☐No

Hospitalized Within 3 Months? ☐ Yes ☐No Month Retro Needed: _____

Attending School? ☐ Yes ☐No

Any Disabilities? ☐ Yes ☐No Type: _____

Was in Foster Care? ☐ Yes ☐No

Are You or Anyone in Your Family Pregnant? ☐ Yes ☐No
Who? _____ Expected Due Date: _____

Interested in Covered California? ☐ Yes ☐No

Please Save and Submit your completed application via email to the Health Benefits Resource Center at:

sfmc-hbrcenrollment@primehealthcare.com

Upon receiving your application, one of our Health Benefits Enrollment Specialists will follow up with you within 7 days.
If you have any questions or need assistance with your application, please contact us at (310) 900-7444.
Thank you!