CHDC
Your Health.
Our Community.

Community Health and Dental Care, Inc.

Health Care Discount Application

Please fill out the application completely and attach all income information.

PERSONAL INFORMATION

Last Name:	First Name:
Date of Birth:	Social Security Number:
Home Address:	Home Phone Number:
	Cell Phone Number:
City/State/Zip:	Email:

Are you currently insured? (check one only)
☐ Yes
☐ No

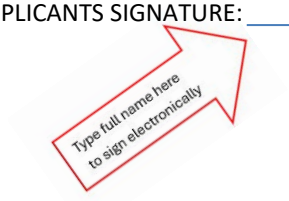
Do you need assistance verifying eligibility for insurance? (check one only)
☐ Yes
☐ No

HOUSEHOLD INFORMATION - List household members claimed on tax form (1040, 1040A and/or 1040EZ) and/or other forms

NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	RELATIONSHIP

I have completed this application for health care discount eligibility and confirm that all my information is correct to the best of my knowledge. If a 100% health care discount is approved, I understand a minimum payment of **$25.00** for Medical/Vision/BH, **$40.00** for Dental Services and **$7.00** for Dispensary will be collected at the time of each visit. I understand that discounts are available regardless of my insurance status and if I do not qualify for a discount, I will be responsible to pay 100% of billed charges. For example, if I am eligible for an 80% discount I will be responsible for 20% of the applicable charges. **I am aware that this discount does not apply to Dental and Medical lab fees**. I understand for self-declared individuals that my slide discount may change subject to administrative approval. I understand this is an application and subject to administrative approval. Once all paperwork and required documents have been received, CHDC will notify applicants of their discount eligibility within 24-48 business hours.

APPLICANTS SIGNATURE: _____ Date: _____



Form collected by: _____