## 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)

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Yes

No

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Do you need assistance verifying eligibility for insurance? (check one only)

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Yes

No

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

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| --- | --- | --- | --- |
| NAME | SOCIAL SECURITY NO. | DATE OF BIRTH | RELATIONSHIP |
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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, contact lens services, or vision charges other than basic frames with single or bifocal lenses**. 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.

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| --- | --- | --- | --- | --- |
| Applicant’s Signature: | |  | Date: |  |
|  | | *(Print name above to sign electronically)* |  | |
| **Form Collected By:** |  | | | |