CHDC Your Health. Our Community.

ch-dc.org
610-326-9460

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	SSN	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 lab fees, Medical lab fees, Vision contact lenses, and premium frames/lenses/add-ons. 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.

I give CHDC permission to send emails/texts or leave phone messages regarding my eligibility: ☐ Yes ☐ No Initials: _____

Applicant's Signature: _____ Date: _____

(Print name above to sign electronically)

Form collected by: _____