

Access Plan Application

Guarantor ID	
Access Plan Effective Date	
Slide Level	

Please indicate which type of income your household receives AND provide proof of all household income.

	HOUSEHOLD				
SOURCE OF INCOME	RECEIVES	ACCEPTED DOCUMENTATION			
SOURCE OF INCOME	RECEIVES				
		Most recent Federal Income tax return			
Employment Income	YES/NO	• Last (2) paystubs			
		Letter from employer validating hours/wages			
Immigration Income	YES/NO	Immigration forms I20 or J1			
Self-Employment	YES/NO	Current Income Statement			
		Prior year income tax return			
Public Assistance – TANF/MFIP	YES/NO	Award Letter(s) listing amount received (current year)			
SSDI	YES/NO	Award Letter(s) listing amount received (current year)			
Social Security Benefits	YES/NO	Award Letter(s) listing amount received (current year)			
Unemployment Compensation	YES/NO	Benefit Award Letter (current year)			
Worker's Compensation	YES/NO	Benefit Award Letter (current year)			
Retirement/Pension	YES/NO	Plan administrator documentation stating monthly benefit			
		amount (current year)			
		Letter from previous employer documenting last day of			
No Income	YES/NO	employment			
		Letter from Case Worker (agency letterhead required)			
		Tax Transcript			
		Denial letter from unemployment			

Please complete table for applicant and all other individuals within the household regardless of insurance status.

Name	Date of Birth	Social Security Number	Relationship	Guarantor	Type of Health Insurance	Patient ID #	Pt Profile	CHE
			SELF (head of household)					

Additional Questions when Claiming Zero Income:
How are you gaining access to the following resources?
Shelter:
Food:
Other Living needs:

Guarantor M	lailing Address:		City:	State:	Zip:			
Phone #: () -	Email Address:						
Do you consi Yes/No If yes	ider yourself homeless? es, location:		Marital Status: Sing Separated Widowe		Divorced			
PLEASE 1	READ CAREFULI	LY AND INITIAL I	BEFORE SIGNING	r				
Initials	Additionally, I under	stand that any services p	nominal fee that is due a processed at Family Heal e sent to an outside facility	thCare will qua	alify for the Access			
Initials	By signing below, I agree to provide Family HealthCare with all mandatory information, for all requested individuals, to determine discount qualification and I understand that my Access Plan will not be affective until all requirements have been met.							
			tor) accepts financial res	ponsibility for	everyone listed on			
status require	this application (exceed to reapply for the Acceed notification to Family Fination of Access Plan e	IealthCare within 30 day	changes to household size					
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INTERNAL ONLY	App Started	Document Rec'd	App Completed	CHE Info Updated	Scanned in Chart	Statement turned on	Allocation Type for primary ins
Staff Initials							