FAMILY HealthCare

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.

SOURCE OF INCOME	HOUSEHOLD RECEIVES	ACCEPTED DOCUMENTATION
Employment Income	YES/NO	• Most recent Federal Income tax return • 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)
No Income	YES/NO	• Letter from previous employer documenting last day of 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	Pt. Srv
			SELF (head of household)					

Guarantor Mailing Address:		City:	State:	Zip:
Phone #: ( ) -	Email Address:			
Do you consider yourself homeless? ***Yes/No*** *If yes, location:*		**Marital Status:** Single Married Divorced Separated Widowed Other_____		

PLEASE READ CAREFULLY AND INITIAL BEFORE SIGNING

_____ Initials

By signing below, I understand that there is a nominal fee that is due at the time of EACH visit. Additionally, I understand that any services processed at Family HealthCare will qualify for the Access Plan Discount; however, any services that are sent to an outside facility will be my personal financial responsibility.

_____ 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.

_____ Initials

The above-named head of household (guarantor) accepts financial responsibility for everyone listed on this application (except for other guarantors).

I will be asked to reapply for the Access Plan annually. Any changes to household size, income, or insurance status require notification to Family HealthCare within 30 days. Failure to provide updated information may result in termination of Access Plan eligibility.

I verify that all information provided on this form is true and correct. Fraudulent self-reporting on any portion of this application may jeopardize your status at Family HealthCare.

X_____ _____

Applicant Signature **(Circle if applies) via phone** Date

Additional Questions when household is claiming zero income:
How are you gaining access to the following resources?
Shelter: _____
Food: _____
Other Living needs: _____

FOR FAMILY HEALTHCARE USE ONLY

Total Gross Annual Income: $_____ Staff Initials_____

- ☐ Paid bi-weekly = two paystubs x 13 (to get pay for 52 weeks)
- ☐ Paid twice a month = two paystubs x 12 months
- ☐ Paid weekly = two paystubs x 26 weeks
- ☐ Paid monthly = two paystubs x 6 months
- ☐ Other _____

GUARANTOR AUTHORIZATION: I received authorization from above listed Guarantor (head of household) to complete this access plan application with Patient ID _____ on _____. _____ (staff initials

☐ **Leave Statement on for HHS with active address**

INTERNAL ONLY	App Started	Document Rec'd	App Completed	Pt Srv Updated	Billing Profile	Scanned in Chart	Statement Turned On	Allocation Type for Primary Ins
Staff Initials								