Community Health Assistance Program (CHAP)

Application Number: _____

Patient Name	If patient is a minor, Guarantor Name
Patient Date of Birth	

BELOW, LIST THOSE FAMILY MEMBERS ARE INCLUDED IN YOUR HOUSEHOLD:

Family is defined as an individual or a group of two people or more related by birth, adoption, marriage and residing together.

Name	Relationship	Social Security #	Date of Birth	SICHC Patient	Income	Insurance
1.				Y N	Y N	Y N
2.				Y N	Y N	Y N
3.				Y N	Y N	Y N
4.				Y N	Y N	Y N
5.				Y N	Y N	Y N
6.				Y N	Y N	Y N
7.				Y N	Y N	Y N

Is anyone listed on this application pregnant? □ Yes □ No
Has patient applied for Medicaid or Insurance in the past 30 days?
Yes_____/Date_____ No_____

Please attach a copy of the most recent federal income tax return supporting the income for the individuals listed above. If a federal income tax return is not available or you are not required to file a tax return, please complete the Patient Self Declaration of Income Form located on the back of this application.

You will have **30 days** to provide all the required information/documentation. If you do not provide *ALL* the information/documents, the CHAP Application will be *DENIED.* This means that the applicant and all household members will pay in full, until the required information/documents are received and a new CHAP application is completed.

I certify the information shown above is accurate and true. I understand that if I have provided false information, my account will default to the full amount due for services rendered. I also understand that this application is valid until the following April 30th, after which time, I will be asked to update my information.

Applicant's Signature_____
Date: _____
Phone Number: _____

Please complete the following table ONLY if a federal income tax return is <u>not</u> available to support the income of those individuals listed on page one.

<u>PATIENT SELF-DECLARATION OF INCOME FORM</u>

Below, provide the <u>annual</u> income for all family members over 19 years of age who are listed on the prior page if a federal tax return is not available.

Name					
Wages & Tips					
Social Security					
Pensions & Annuities					
Veteran Payments					
Unemployment					
Workers Compensation					
Self Employment					
Interest & Dividends					
Rental Income					
Child Support/Alimony					
Other Income:					
Total					

Please provide the following documentation:

-pay check stubs to support the wages shown above

-support for any social security, pension and annuity income.

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I declare that the income information above is correct and accurately reflects my financial position. I am aware that providing false information will result in all discounts within the sliding fee discount program being revoked and the full balance of the accounts restored.

Signature: _____

FOR OFFICE USE ONLY

SICHC Employee Application Acceptance _____ **Date** _____

SICHC Application Review & Approval _____ **Date** _____

Number of Members In Household	
Annual Income	

Discount Approved	**Class 1 Nominal Fee**	**Class 2 Pay 30%**	**Class 3 Pay 40%**	**Class 4 Pay 60%**	**Class 5 Pay 80%**

Application Expiration Date: