Cassie Health Center for Women

Patient Registration Form/Family Assistance Plan Application

Name of Head of Household		Place of Employment		
Mailing Address	City	State	Zip	Phone
Health Insurance Plan		Social Security Number		

Please list spouse and dependents under age 18

Name		Date of Birth	Name		Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Rent, interest, dividend, and other income				
Total Income				

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's license, birth certificate, employment ID, and social security card		
Income: Prior year tax return and two (2) most recent pay stubs		
Insurance: Insurance card (s)		
Medicaid: Application made or evidence of rejection		

I certify that the information shown above is correct and understand verification is required for approval.

Name (Print) ______________________

Signature/Date ______________________

Office Use Only

Pay class approved: ______________________ Effective Date: ______________________

Approved by: ______________________ Effective Date: ______________________

All information on this Application is kept confidential. By signing this Application, you are stating that all information is true and accurate to the best of your knowledge. Falsifying information can lead to a reversal of this Application and charges will be filed against you in the State of New Mexico.