Cassie Health Center

Patient Registration Form/Family Assistance Plan Application

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

Please list spouse and dependents under 18 years of age

	Name	Date of Birth		Name/Relationship	Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

Gross Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits (SSI, Survivor's, Disability)				
Income from business self employment, and dependents (net receipts after deductions)**				
Public Assistance (TANF, General Assistance, etc.)				
Rent, interest, dividends, stocks, and other income (received)				
Child Support/Alimony				
Unemployment Benefits, Workers' Compensation				
Total Income				

****If you are self-employed, you must bring a copy of 1040 with schedule C attached, latest 12 months of Gross Receipt Tax, and or a Profit and Loss Statement.**

Without proof of income your application will not be processed and your enrollment into the program will be delayed. If there are special issues you feel should be considered when we review your application, please include on a separate piece of paper.

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's license, birth certificate, 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		

YOU MUST INCLUDE PROOF OF INCOME SUCH AS FEDERAL TAX RETURN; MEDICAID, MEDICARE, OR SOCIAL SECURITY AWARD LETTERS AND CHECK STUBS; AND/OR COPIES OF UNEMPLOYMENT CHECKS.

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

______________________________ ______________________________

Name (Print) **Signature/Date**

Help is available in applying for Medicaid or other state coverage insurance. Please inquire in the billing office.

Office Use Only

Pay class approved: ____________________________ **Effective Date:** __________________________

Approved by: ________________________________ **Expiratione Date:** ________________________

Applications are updated annually upon one (1) year of expiration of current application.