MARIAS HEALTHCARE
FQHC Assistance Plan Application

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

Please list spouse and dependents under age 18

Name	Date of Birth	Social Security Number	Medicaid
Self			
Spouse			
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 of Income Checklist(attach all copies that apply)	Yes	No
Prior year tax return		
Three most recent pay stubs		
Social security, pension, annuity, or veteran's benefits		
Alimony, child support, military family allotment		
Other		

I certify that the information shown above is correct and understand verification is required for approval. I understand that should any changes occur within my coverage period, I am responsible for providing Marias Healthcare with the updated information.

_____ _____

Signature Date

Office Use Only

RP#_____ Total # in Household_____ Total Income_____

Discount_____% Code_____ Coverage period_____

Approved by:_____ Date_____