Name (Please Print): _____Date: _____
Last First Middle

Date of Birth: _____ Social Security Number: _____

PLEASE COMPLETE THE ENTIRE FIRST BOX BELOW EVEN IF YOU HAVE INSURANCE.

Number of people supported by income ____
Household gross income (before taxes) is $_____ (**week/month**)
Add child support $_____ (**week/month**)
Add cash assistance $_____ (**week/month**)
Add Social Security benefits $_____ (**week/month**)
Add any other income $_____ (**week/month**)

*If you are recently **employed or self-employed and do not have a pay stub, please complete** to help determine your income.
I will be paid $_____ per hour, I expect to work _____ hours per week. I will be paid **weekly/bi-weekly/monthly.**

My spouse (or significant other) will be paid $_____ per hour, and expect to work_____ hours per week.
My spouse (or significant other will be paid **weekly/bi-weekly** or **monthly**.

PLEASE COMPLETE ONLY ONE BOX BELOW.

__**Please bill my Medicaid or Insurance. I understand I am responsible for any remaining portion/deductible.**

Primary
Medicaid/Insurance Provider: _____
Group/Member Number: _____
Policy Holder Name: _____
Policy Holder Date of Birth: _____ Relationship: _____

Secondary
Medicaid/Insurance Provider: _____
Group/Member Number: _____
Policy Holder Name: _____
Policy Holder Date of Birth: _____ Relationship: _____

__**I would like to apply for reduced fees.**

__ **I DO NOT wish to apply for reduced fees at this time. I will pay 100% of my fees with cash, check or credit card.**

I verify that the information I have provided is correct to the best of my knowledge. Program officials may verify the information on this form. I understand that deliberate misrepresentation may subject me to civil or criminal prosecution. I hereby acknowledge receiving a copy of this form if requested.

Signature: _____Date: _____

Witness: _____Date: _____