Membership Application - HealthShare Discount Program

□ *I would like to apply for the HealthShare Discount Program and receive discounts on my medical visits*.

□ *I do not wish to apply for the HealthShare Discount Program <u>because my income is over 200% Federal Poverty Guidelines</u>. I understand that I will be charged the full fees for all medical visits.*

□ *I do not wish to apply for the HealthShare Discount Program for <u>other reasons</u>. I understand that I will be charged the full fees for all medical visits.*

□ *I am on AHCCCS or Utah Medicaid. Patient may skip and sign bottom of this form.*

PATIENT GENERAL INFORMATION

Patient's Name: _____

Patient's Birth Date: _____

Date of Service: _____

Has patient applied for Medicare/Medicaid/KidsCare within the last 3 months? □ Yes □ No

INCOME DEFINITION

This form verifies income for 30 days. After 30 days, patient must provide additional income verification (see below). Household income includes combined income by all household members from the following sources:

- Salaries and Wages from employment
- Earnings from Self-Employment (minus business expenses, excluding depreciation and capital loss carry-over)
- Interest and Dividend Investment Income
- All Investment and Rental Income, excluding depreciation
- Unemployment Benefits
- Workers' Compensation
- Alimony
- Child Support
- Military Allotments
- Social Security and other Government Benefits
- VA Benefits
- Retirement and Pension Income

Patient's Total Household Income $_____

INCOME VERIFICATION

Creek Valley Health Clinic requires one of the following as income verification:

- Pay stub (most current)
- Signed note from current employer itemizing client's income before taxes
- W-2 forms
- Income tax return (most recent filing year)
- 1099 forms
- Social Security/ Veteran's Administration/ Railroad Retirement benefits letter
- Unemployment documentation
- Bank statements

HOUSEHOLD MEMBERS

Household is defined as up to two adult partners and their dependent children up to age 26, similar to who would qualify as a group for medical insurance, or for federal income tax return purposes.

Please list ALL members of the household.

Name	Relationship to Patient	Age	Employed at:	Individuals Estimated Annual Salary
	SELF			

AGREEMENT AND SIGNATURE

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I accepted as a member of the HealthShare Partnership, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal of the HealthShare Discount Program.

Name of Patient or Guardian (Printed)	
Signature of Patient *or* Guardian if patient is under 18	
Physical Address	
Date	

Thank you for completing this application form and for your interest in joining our HealthShare Discount Program. This program is available to all patients, regardless of income or insurance status.

Staff Use Only: This section applies to AHCCCS and Utah Medicaid Patients Only:

Patient has attested family size of ____ members, and income is Less Than / Greater Than $_____