VOLUNTEER HEALTH CARE PROVIDER PROGRAM - FINANCIAL ELIGIBILITY FORM

CLINIC/PROGRAM/PROVIDER: Light Ones Path Foundation, Inc. / Sunshine Charity Clinic

810 S STATE ROAD 7 PLANTATION, FLORIDA 33317 Phone: 954-234-6659

Section 1 **Do you have insurance that covers your health or dental condition? YES _____NO ______**
Does anyone in your family have an active FL Medicaid card? YES ____ NO ____

Name of the card holder and Medicaid No. ____

Client's/Head of Household's Name: ____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: ____
(STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: ____________________ Name of Contact: ____________________

Section 2
Family Size: Adults____ Under 18 ____ 18-21--Student ____ Unborn ______ Family Size TOTAL _______

FAMILY MEMBERS NAME **DOB**	**EMPLOYER**	**GROSS EARNED INCOME LAST 4 WKS**	**GROSS UNEARNED INCOME LAST 4 WKS** (Do not include TANF or SSI)
SELF		**$**	**$**
SPOUSE		**$**	**$**
CHILD		**$**	**$**
CHILD		**$**	**$**
CHILD		**$**	**$**
CHILD		**$**	**$**
	TOTALS	**$**	**$**
	Add earned and unearned income	to determine total	**TOTAL INCOME** **$**____________

Section 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)

Step 1.	**"TOTAL FAMILY INCOME"** for family unit (Earned and unearned income).	(1) $____________(Above)
Step 2.	Subtract $90 for <u>EACH</u> employed member of the family unit.	(2) $____________(Minus)
		(2a) $____________ (Total)
Step 3.	Subtract childcare <u>PAID</u> each month (up to $175 per child age 2 and older; up to $200 per child under age 2).	(3) $____________(Minus)
		(3a) $____________(Total)
Step 4.	Subtract up to $50 per month of total child support received.	(4) $____________ (Minus)
Step 5.	**TOTAL NET INCOME**	(5) $____________(Total)

Section 4 **USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION**

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit. I acknowledge receipt of the Department of Health's Notice of Privacy Practices.

X______________________________ ______________________________
SIGNATURE OF CLIENT/PARENT OR GUARDIAN **DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE DATE**

(VALID FOR ONE YEAR) Expiration date: ____________________