VOLUNTEER HEALTH CARE PROVIDER PROGRAM - FINANCIAL ELIGIBILITY FORM

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

601 East Sample Rd., Suite 101, Deerfield Beach FL, 33064 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 EACH employed member of the family unit. (2) $_____(Minus)

(2a) $_____ (Total)

Step 3. Subtract childcare PAID 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: _____

DH 1032E (07/13)