MATERNAL CHILD HEALTH/DENTAL SERVICES FINANCIAL FORM INSTRUCTION SHEET

PURPOSE: To provide information on how to complete this required form.
Note: <u>The processing time of application is delayed when the application is not completed</u>.

1. Client's Name: Name of person for whom the application is being made.
2. Date of Birth: Date the client was born.
3. Client's Address: Address where the client lives at the present time (house/apt. number, street name, city, state and zip code), home telephone number, and address where family receives their mail (PO Box).

A. **MEDICAL INSURANCE INFORMATION**:
If you have any type of medical insurance including EqualityCare (Medicaid) and KidCare Chip (Blue Cross) please complete Section A.

1. Name and address of person responsible to carry insurance for the client. If a parent, who is not living in the house, is required to carry health insurance *or* assist with medical bills for the client, please provide the name/address of this parent. A copy of the court order or divorce decree may be required.
2. A copy of your insurance card.
3. Name of insurance company.
4. Please check the appropriate box indicating if client's condition is covered by insurance.
5. Policy number.
6. Amount of Deductibles/Co-payments.
7. How much per month is paid or is taken out of your paycheck to buy medical insurance. This is important because it is used to determine eligibility.

B. **FAMILY INCOME**:
{Includes the eligible client, spouse, parent(s), stepparent or legal guardian(s), all minor children and any dependant adult living <u>in the house</u> who are financially dependant upon the client, spouse, parent(s), stepparent or legal guardian(s)}. **Total number of family members in the household has to be completed to process application.**

1. Need all income information from client, spouse, parent(s), stepparent or legal guardian(s) who are in the household. Please write in the relationship to the client (i.e. client, spouse, father, mother…).
2. If any of the above household members are self-employed, we require a copy of the most recent Income Tax Return to process the application.
3. List occupation, current employer, how many months of the year worked, months and/or years at current job, and **<u>monthly gross earnings</u>** (amount earned before taxes or any deductions are taken out).
4. Total amount in savings.
5. Child support, alimony, family or military benefits received each month by any household member.
6. Social Security, SSI, SSDI, retirement or survivor benefits received each month by any household member.
7. Other income received from dividends/interest (i.e. savings), business income (i.e. rental income), real estate, Royalties, Pensions. Annuity Payments and Estates/Trusts by any household member. Indicate if received monthly, quarterly, or annually.
8. Unemployment, Workman's Compensation, Strike benefits and/or Training stipends received each month by any household member.
9. EXPENSES: Amount of child support paid out each month.

C. **CITIZENSHIP**:

1. Circle yes or no for U.S. Citizenship.
2. If no, please put your Non-Citizen / Alien Registration Number.

Your signature certifies that the citizenship/immigration status is correct for each person applying. You do not have to give information on citizenship or immigration status of family members who are not applying for health care benefits. It is understood that your records will be kept confidential and will only be released for purposes authorized by you or required by federal and state law. Information provided on this application is not routinely provided to Immigration and Naturalization Service (INS).

4. It is required that you fill in the client's name in the space marked "I (we) apply for the care of _____ by Maternal Child Health/Dental Services." **<u>Your signature and date is required</u>** before we can complete your application.

Thank you. If you have questions on completing this form, please call your local Public Health Nurse/Care Coordinator.