Pinellas County Health & Community Services Department

Application for Medical Services

Pinellas County Health & Community Services Department (PCHCS) offers medical services for eligible clients through temporary enrollment into its medical plan upon discharge from the hospital. In order to determine eligibility the following information is needed for your potential enrollment. Please answer the following questions completely and accurately. Sign your application along with the accompanying Release of Information and Rights & Responsibility forms. Supporting documents for income verification **MUST** be included along with proof of identification, Social Security card, and support statements from any other individuals or groups currently assisting you.

Upon review of your application, PCHCS may require further information to determine eligibility. If determined eligible, enrollment into the County's medical plan will be enacted to cover your immediate home health care need(s) but for no longer than a period of two weeks. To extend your enrollment you must complete eligibility at one of PCHCS's medical homes. If it is concluded that eligibility was granted under false pretensions because of false or incomplete information presented by you, eligibility and services will be rescinded immediately and possible prosecution could result.

Client Information

Name (Last, first)		Room Number:
Social Security Number:	Date of Birth:	
U.S. Citizen: Yes or No If no, current alien status:	Veteran? ◯ or ◯ Date of Service: Branch: Discharge Status:	
Your current address: County of Residence:	Mailing Address (if different): Home Phone:	
Employer:	Work Phone:	Supervisor:
Spouse or Significant Other:	SSN:	Do you have minor children in your custody? If so, how many?

Insurance

If you have Medical/Health insurance, please provide that information below. Also, if your hospitalization the result of an injury or accident, please provide us with the needed Auto/Homeowner's/Workman's Compensation or Third Party insurance information below.

Insurance Co:_____ Policy #:_____ Type_____
Address:_____ Phone:_____
City/State/Zip:_____Insured_____ SSN of Insured_____
Attorney Name/Address/Phone_____
Nature of injury/accident_____
_____
_____
_____
Police Report Number_____ What police agency responded to this accident?

Household Members & Income Information

Please list all household members and include all sources of income for your immediate family members (spouse/significant other and children). Include all employment and non-employment sources, such as Workman's Compensation, Social Security, VA benefits, Unemployment Benefits, pensions, rental income, interest from investments, dividends, etc.

Family Member	Gross Monthly Income	Source of Income
Self		
Spouse/Significant Other		
Child DOB:		
Child DOB:		
Child DOB:		
Other Relationship to You:		

- If you have no income, please explain how your monthly expenses are paid
- If supported by someone, that person must complete a support statement (Form HS-9)

Monthly Household Expenses

Rent/Mortgage:_____ Transportation:_____ Credit Card(s):_____
Electric:_____ Child Care:_____ Water:_____
Alimony:_____ Health/Life Ins:_____ Auto Ins:_____
Gas:_____ Gasoline:_____ Cable:_____
Auto Payment:_____ Child Support:_____ Other (please define)_____
Food:_____ Medications:_____ _____

Total Monthly Expenses_____ Total Monthly Income_____ Difference _____
If a Negative Amount, please explain how the difference is met:_____
_____

Have you applied for any of the following?
SSI_____ If yes, when?_____ Current Status:_____
SSDI_____ If yes, when?_____ Current Status:_____
Application is based on what diagnosis?_____

I am applying for assistance from the Pinellas County Health & Community Services Department (PCHCS) and I am aware that I am responsible for cooperating and assisting fully in the determination of my eligibility. I agree that PCHCS may verify the information, including employment that I give on this form. I understand there is a law providing for imprisonment or fine for anyone withholding or giving false information or receiving assistance to which he/she is not entitled. This is to certify that the information I have given on this application is true & correct. If it is concluded that eligibility was granted under false pretenses because of false or incorrect information presented by you, eligibility and services will be rescinded immediately and possible prosecution could result. Please provide any additional information necessary for your eligibility determination on a separate sheet of paper.

_____ _____

Client Signature Date Witness Signature Date