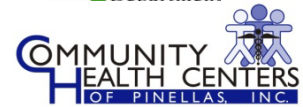




Pinellas County Health Program APPLICATION DOCUMENTS

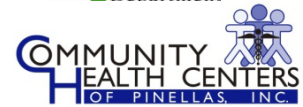


In order to apply for the Pinellas County Health Program (PCHP), you need to bring the following documentation:

Proof of Residency	<p>One of the following documents with your name and a current Pinellas County address:</p> <ul style="list-style-type: none"> • Pinellas County Financial Assistance ES7 – Information and Referral Form (valid for 30 days) • Current Florida Drivers License or Florida ID Card • Mortgage, lease, rent receipt or letter from a landlord • Water, electric, or other utility bill • Proof of home ownership- tax bill • Homestead exemption documentation • Vehicle registration/ boat registration • Pinellas County voter identification card • Proof of children enrolled in Pinellas County schools • Government agency mailing • Forwarded mail with USPS forwarding sticker indicating the new Pinellas County address • Declaration of domicile recorded with Clerk of Court in Pinellas County • Professional license with home address in Pinellas County • Law enforcement document or letter on law enforcement letterhead (e.g. Department of Corrections) • Print out from official judicial or law enforcement web site • Bank or other financial document indicating home address in Pinellas County • Employment Record, including pay stubs and W-2 forms, indicating home address in Pinellas County • Statement from another social service agency specifying residency
Proof of Age	<p>One of the following documents with your name and birth date:</p> <ul style="list-style-type: none"> • Pinellas County Financial Assistance ES7 – Information and Referral Form (valid for 30 days) • Florida Drivers License or Florida ID Card • Birth Certificate • Other government issued identification card with birth date
Proof of Identity	Social Security Card or a printout from the Social Security Administration (SSA) with a Social Security number
Proof of Citizenship	<p>Appropriate document if US citizen born outside of the US, naturalized citizen, refugee/asylee, or legal permanent resident:</p> <ul style="list-style-type: none"> • Pinellas County Financial Assistance ES7 – Information and Referral Form (valid for 30 days) • Birth Certificate or U.S. passport for US Citizens born <i>outside</i> of the United States • Valid U.S. passport or Certificate of Naturalization for naturalized citizens • Form I-94 for refugees and asylees • Current I-551 forms and release of sponsorship <i>or</i> 40 work hour credits for legal permanent residents
If you have custody of blood-related or adopted children	Proof of Medically Needy Share of Cost
If you receive SSDI	Proof of Medically Needy Share of Cost
Proof of Income	<p>You must provide proof of all sources of earned <u>and</u> unearned income, including:</p> <ul style="list-style-type: none"> • If employed, paystubs from previous four-week period • If self-employed, three months of earnings and business related operating expenses • Educational award documentation for grants, loans and scholarships for current enrollment period • Receipts for earnings, rents, or royalties • Statements for compensation or payments from Unemployment, Workers' Compensation, Social Security or SSI, Public assistance, Department of Veterans Affairs, survivor benefits, pension or retirement income • Bank or Financial Statements showing interest, dividends, or automatic deposits for income • Any documentation showing income from estates, trusts, alimony, child support, or other sources



Pinellas County Health Program APPLICATION



The Pinellas County Department of Health and Human Services collects your Social Security number in order to process billing and payments on your behalf as a client of the Department. Your Social Security number is also used as a unique numeric identifier and may be used for search purposes. This notice is provided pursuant to Section 119.071(5) Florida Statutes (2007).

Date Application Submitted to Medical Home: _____ Reason for visit? _____

SECTION I: RESIDENCY, AGE, IDENTITY & CITIZENSHIP

Your Name (Last, First, MI)		Social Security #		DOB		Phone #	
Current Address		Apt. #	City		State	Zip	Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No
Race	Ethnicity Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Email Address		

Marital Status: Single Married Divorced Separated Widow(er)

How old are you? _____

Do you receive Financial Assistance from Pinellas County? Yes No

ES-7 (optional)

Are you on vacation or living temporarily in Pinellas County? Yes No

Are you a part-time or full-time student? Yes, Full-time Yes, Part-time No

Proof of no insurance

If yes, are you attending school from out-of-state? Yes No

What school do you attend? _____

Please select your citizenship status:

- Born in the United States or in a U.S. territory (Puerto Rico, Guam, U.S Virgin Islands, etc.)
- Born *abroad* to a U.S citizen
- Naturalized U.S. citizen
- Refugee or asylee
- Non-sponsored, legal permanent resident
- Other: _____

Birth Certificate
 Current U.S. Passport or Certificate of Naturalization
 I-94
 I-551 and Release of Sponsorship -or- 40 work credits

SECTION II: OTHER COVERAGE

Please select any benefits you currently receive:

- Insurance (medical, dental)
- Medically Needy Share of Cost (MNSOC)
- Cobra Insurance
- SSI
- Medicaid
- SSDI
- Medicare
- VA Healthcare

Have you ever served in the military? Yes No

Call VHA

Is this visit related to an accident, injury, or work related injury? Yes No

MH6 – CM Referral

If yes, are you receiving worker's compensation or Division of Vocational Rehabilitation services? Yes No

Do you have custody of any blood-related or adopted children? Yes No

MNSOC

OFFICE USE ONLY- PLEASE PRINT

Enrollment Type: <input type="checkbox"/> New Client <input type="checkbox"/> Annual Renewal	Eligibility Period (in most cases, one year):
Eligibility Determined At:	From: (/ /) To: (/ /)
Assigned Medical Home:	
Staff Contact Name:	Staff Contact Phone:

Please fax this page to PCHHS at (727) 464-8428.

SECTION III: HOUSEHOLD MEMBERS & INCOME

Please list all the people that live in your house, including the mother or father of your children (even if you are not married).

HH #	Household Members' Names (In Addition to You)	Relationship to You	Social Security #	DOB	Staff Only AG? (<input type="checkbox"/> if yes)
2.					
3.					
4.					
5.					
6.					

Please select **all** sources of income for you and your household members:

Self		Spouse/Child/Partner/Parent of Child		
<input type="checkbox"/> Full-time or part-time employment		<input type="checkbox"/> Full-time or part-time employment		
<input type="checkbox"/> Self-employment (Use Worksheet)		<input type="checkbox"/> Self-employment (Use Worksheet)		
<input type="checkbox"/> Education Assistance (Use Worksheet)		<input type="checkbox"/> Education Assistance (Use Worksheet)		
		HH#: _____	HH#: _____	HH#: _____
<input type="checkbox"/> Unemployment (before taxes) Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Assistance from outside the household Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Workers' Compensation Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Social Security Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> SSI Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Public Assistance Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> VA Disability Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Credit Card Cash Advances Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Home Equity Line of Credit Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Survivor Benefits Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Pension or Retirement Income Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Interest or Dividends Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Rent or Royalty Income Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Estate and Trust Income Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Alimony Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Child Support Amount \$ _____		\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Other sources of money Amount \$ _____		\$ _____	\$ _____	\$ _____

*You **must** provide proof of **all** sources of income to the Medical Home staff for enrollment.

SECTION IV: APPLICANT DECLARATION

By my signature, I certify that the information I have given on all pages of this application is correct. If I commit fraud, my eligibility for services may be rescinded immediately and my case may be referred to the appropriate law enforcement agency for possible criminal investigation and prosecution.

I must keep the Pinellas County Health Program (PCHP) aware of changes to my address, household composition, and income. I agree that PCHP may verify the information on this form and at my interview by calling to verify information or running electronic background checks.

I understand that if I require care outside my medical home, PCHP may ask me to produce documentation of assets. These assets may affect my ability to receive specialty and hospital care based services.

I also understand the conditions and expectations of the PCHP regarding behavior. I have received and signed a copy of the PCHP Behavior Contract. Receiving health care services through the PCHP is a privilege which will be immediately revoked if my behavior does not meet the standards established by the program and/or my behavior threatens myself or others in any way.

Applicant Name (Print) _____ Signature _____ Date ___/___/___

FOR OFFICIAL USE ONLY – INCOME CALCULATIONS

Instructions:

1. Add all the gross earned and unearned income (before taxes).
2. Multiply this total by 0.85 to determine the **adjusted income**.
3. Compare **adjusted income** for the assistance group to the current income limits in Appendix A.

Applicant

Date Range: From _____ To _____

Source (copy and attach verification)

Spouse/Partner/Parent of Child/Child with income

Date Range: From _____ To _____

Source (copy and attach verification)

	Gross Earned Income
Week 1	\$ _____
Week 2	\$ _____
Week 3	\$ _____
Week 4	\$ _____
SUBTOTAL	\$ _____

	Gross Earned Income
Week 1	\$ _____
Week 2	\$ _____
Week 3	\$ _____
Week 4	\$ _____
SUBTOTAL	\$ _____

Monthly Gross Earned Income (Combined subtotals from above)	\$ _____
Monthly Self-Employed/Student Income (Self-employment/Student Worksheet)	\$ _____
Total Monthly Unearned Income (Add all income under gray bar in income section)	\$ _____
= Total Monthly Gross Income	= _____
TOTAL MONTHLY ADJUSTED INCOME	x 0.85
	\$ _____

ADDITIONAL CASE NOTES

Please state any additional comments or notes about the application (i.e. Case Manager Referrals, Calls made to outside agencies to prove applicant is not eligible for Alternative Coverage, etc.):

Is applicant eligible for PCHP? YES__ NO__ (If YES, please fax completed first page to PCHHS within **one business day**.)

Did I provide the applicant with a copy of the PCHP Behavior Contract? YES__ NO__

Did I provide the applicant with a PCHP Identification Card? YES__ NO__

Did I provide the applicant with the PCHP Client Handbook? YES__ NO__

Intake Staff Name (Print) _____ Signature _____ Date ___/___/___

Verification Notes:

Verifying Staff Name (Print) _____ Signature _____ Date ___/___/___