

****If you are self-employed, you must provide your most recent Federal Income Tax Return (1040) with accompanying Section C.**

YOU MUST INCLUDE PROOF OF INCOME SUCH AS PAYCHECK STUBS, COPIES OF UNEMPLOYMENT CHECKS AND/OR SOCIAL SECURITY CHECKS.

Without proof of income our application will not be processed and your enrollment into the program will be delayed. If you have difficulty getting proof of income, speak to the Medical Center's Customer Service Representative who can assist in recommending sources of proof. If there are special issues you feel should be considered when we review your application, please include on a separate piece of paper.

ZERO INCOME

PLEASE FILL OUT ONLY IF YOU HAVE NO SOURCE OF INCOME

Name of last employer: _____ Date of last employment: _____

Please explain how your basic needs have been met:

Food: _____ Utilities: _____

Shelter: _____ Non-food items (clothing, etc.): _____

I, _____, certify that I have had no source of income since _____.

All Applicants: PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW.

- I agree to be responsible for my Community Medical Center bills.
- I also agree to tell the Medical Center if I become eligible for any other form of coverage.
- I understand that if I provide false or incomplete information, I may no longer qualify for a fee discount.
- I certify that the above information on this application is correct and all sources of income required have been reported. I further understand that I will need to update my application every six months even if no changes occur.

Signature: _____ **Date:** _____

PHC, Inc. Use Only:

Total No. of Family Members: _____	Payment Eligibility: _____
Combined Family Income: _____	Date of Application: _____
Verification Source: _____	Renewal Date: _____

Application Completed By: _____