

SWEET MEDICAL CENTER, INC.
Health Assistance Program Application

Patient Name _____ Date _____

Do you have any health insurance? _____

Have you applied for Medicare/Medicaid/Healthy Montana Kids? _____ **When?** _____

List ALL members of the household:

| Name | Relationship to the Patient | Date of Birth | Work Place | Full or Part time |
|-------------|------------------------------------|----------------------|-------------------|--------------------------|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |

List ALL sources of Gross Yearly Income for the household:

| | Family Member | Family Member | Family Member | Family Member |
|----------------------------|----------------------|----------------------|----------------------|----------------------|
| Employment(including tips) | | | | |
| Unemployment Compensation | | | | |
| AFDC | | | | |
| Child Support | | | | |
| Pension | | | | |
| Social Security | | | | |
| Other | | | | |
| Total Gross Income | | | | |

(adjusted gross income if using income taxes for proof)

Total Household Income

I affirm that the information I have given is true and accurate.

Signature

Do Not Write Below This Line

Total Number in Household _____ Total Household Yearly Income _____

Discount category (A,B,N) _____ Rate(%) _____ Initials _____ Date _____