

SWEET MEDICAL CENTER, INC.
Health Assistance Program Application

Patient Name _____ Date _____

Have you applied for Medicare/Medicaid/CHIPS? _____ 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