Community Health Center of the Black Hills, Inc

CHCBH Discount Program Application

Name of Patient/Parent/Guardian		Phone	
Street	City	State	Zip
Social Security Number	Place of Employment		

Please list self, spouse, and dependents under age 18

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

OFFICE USE ONLY: Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self-employment, and dependents				
Rent, interest, dividend, and other income				
Total Income				

OFFICE USE ONLY: Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other		
Income: Prior year tax return, two (2) most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection.		

I certify that the information shown above is correct and understand verification is required for approval.

_____ _____

Signature Date

Staff Initial: _____ Date: _____ Recertification Date: _____