COUNTY HEALTH CARE
P.O. BOX 189
SAN DIEGO, TX 78384
PHONE: (361)279-6206 / (361)279-6205
FAX (361)279-8225

APPLICATION FOR COUNTY MEDICAL ASSISTANCE
PLEASE PRINT

APPLICANT'S NAME (LAST, FIRST, MIDDLE) HOME PHONE WORK PHONE

MAILING ADDRESS CITY STATE ZIP CODE

RESIDENCE PHYSICAL ADDRESS CITY STATE ZIP CODE

HOW LONG HAVE YOU LIVED AT CURRENT ADDRESS? _____
PREVIOUS ADDRESS? _____
WHO REFERRED YOU? _____

ANSWER EVERY QUESTION. WRITE "NA" IF THE QUESTION DOES NOT APPLY.
FILL ALL BLANKS FOR EVERYONE WHO LIVES WITH YOU, WHETHER YOU CONSIDER THEM HOUSEHOLD MEMBERS OR NOT.

1.NAME FIRST MIDDLE LAST	RELATIONSHIP TO APPLICANT	D.O.B	AGE	PLACE OF BIRTH	SEX	RACE	SOCIAL SECURITY #
A.							
B.							
C.							
D.							
E.							
F.							
G.							
H.							
I.							
J.							
K.							

ARE YOU AND FAMILY MEMBERS RESIDENTS OF DUVAL COUNTY? YES_____ NO_____
BRING VERIFICATION ON NEXT VISIT

2. EMPLOYMENTHISTORY

NAME OF EMPLOYER_____ADDRESS OF EMPLOYER_____

TYPE OF EMPLOYMENT_____MONTHLY INCOME $_____

SPOUSE'S INCOME $_____

3. DO YOU OR ANYONE IN YOUR HOUSEHOLD RECEIVE MONEY OR BENEFITS FROM THE FOLLOWING SERVICES

CHECK "YES" OR "NO"	YES	NO	AMOUNT
SOCIAL SECURITY			
CHILD SUPPORT			
FOOD STAMPS			
SUPPLEMENTAL SECURITY INCOME (SSI)			
VETERAN'S BENEFITS			
RETIREMENT BENEFITS			
WELFARE CHECKS (TANF)			
UNEMPLOYMENT CHECKS			
WORKERS COMPENSATION			

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS IN ITEM 3, COMPLETE THE FOLLOWING

NAME OF PERSON WORKING OR RECEIVING MONEY	AMOUNT RECEIVED	HOW OFTEN
1.		
2.		
3.		

ARE YOU OR ANYONE IN YOUR FAMILY NOW BEING SERVED BY PRIVATE HEALTH INSURANCE?
"YES"____"NO"____
IF YES NAME OF COMPANY_____

LIST MONTHLY EXPENSES BELOW	**AMOUNT**	**HOW BILLED**	**DATE OF LAST PAYMENT**
1. RENT OR HOUSE PAYMENT			
2.HOME INSURANCE PAYMENTS			
3.TAXES			
4.TELEPHONE			
5.GAS			
6.ELECTRICITY			
7.WATER			
8.FOOD			
9.VEHICLE PAYMENT			
10.VEHICLE INSURANCE			
11.MEDICAL EXPENSES			
12.LOANS			
13.CABLE			
14.CHARGE AMOUNTS			
15.OTHER EXPENSE			

DO YOU OR ANYONE WHO LIVES WITH YOU HAVE ANY OF THE FOLLOWING: VEHICLES YES_____ NO____
LIST YEAR, MAKE AND MODEL OF EACH VEHICLE.
YEAR_____ MODEL_____ MAKE_____

HAVE YOU APPLIED FOR DISABILITY: _____YES _____NO DATE APPLIED: _____

ALL QUESTIONS AND THE STATEMENTS I HAVE MADE ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEFS.

I AGREE TO GIVE ELIGIBILITY STAFF, THE COUNTY, AND INFORMATION NECESSARY TO PROVE STATEMENT ABOUT MY ELIGIBILITY. I WILL COOPERATE FULLY WITH COUNTY PERSONNEL TO GET INFORMATION FROM ANY SOURCE TO PROVE THE STATEMENTS I MADE. I WILL COOPERATE FULLY WITH COUNTY PERSONNEL IN QUALITY CONTROL REVIEW OR AUDIT.

1. MARITAL STATUS: _____
2. INCOME: _____
3. RESOURCES: _____
4. NUMBER OF HOUSEHOLD MEMBERS: _____
5. ADDRESS: _____
6. FOOD STAMPS: _____
7. TOTAL MONTHLY BILLS: _____
8. EXPLAIN MEDICAL NEED:

_____

_____

_____

_____

_____

I HAVE BEEN TOLD AND UNDERSTAND THAT THIS APPLICATION WILL BE **CONSIDERED** WITHOUT REGARD TO **RACE, COLOR, CREED, NATURAL ORIGIN, AGE, SEX, HANDICAP, OR POLITICAL BELIEF:** THAT I MAY REQUEST A REVIEW OF THE DECISION MADE ON MY APPLICATION OR RECERTIFACTION FOR ASSISTANCE AND THAT I MAY REQUEST ORALLY OR IN WRITING FAIR HEARING ABOUT ACTIONS AFFECTING RECEIPT OF OR STOPPING ASSISTANCE.

I UNDERSTAND THAT I MAKE ABOVE STATEMENTS UNDER PENALTY OF FRAUD OR WILLFULLY MISPRESENTATION OF INFORMATION.

GET SIGNATURE OF TWO (2) NON-RELATED OR NON HOUSEHOLD INDIVIDUALS. DUVAL COUNTY HEALTH CARE EMPLOYEES ARE PROHIBITED FROM SERVING AS WITNESSES OR ASSISTING WITH FILLING OUT APPLICATION.

I HEREBY CERTIFY THAT I AM APPLYING FOR SERVIES FROM DUVAL COUNTY HEALTH CARE DEPARTMENT BECAUSE OF **NEED ONLY** AND THAT NO POLITICAL MOTIVE OR PROMISE IS INVOLVED IN THIS REQUEST.

BEFORE YOU SIGN BE SURE EACH ANSWER IS COMPLETE AND CORRECT

_____ _____ _____

SIGNATURE OF APPLICANT DATE SIGNATURE OF SPOUSE

WITNESS:

NAME: _____ DATE: _____

NAME: _____ DATE: _____

APPLICATION FILLED BY:

NAME: _____ ADDRESS: _____

INITIALS: _____