Healthy Neighbor Plan Application 2017

HNP appt date:_____

Valley Community Health Centers (VCHC) is pleased to offer the opportunity to apply for a discount on services provided at VCHC. Discounted services at VCHC are determined by you and your family's annual income. If you feel this may be a benefit, please complete the Healthy Neighbor Plan application and provide verification of income.

Head of Household Information:

Name: First, middle initial, Last):	Social Security Number:	Date of Birth:	County:
Address:	City/State/Zip	Phone Number:	Email Address:

Please include information for all adult family members who are employed: **1) PROOF OF INCOME (INCOME TAX OR LAST TWO PAYSTUBS, ETC.)** ***Income information must be provided within 30 days of your appointment with VCHC***, otherwise services will be rendered at customary price. ***If your income is $0,*** **how are you meeting your food, clothing, shelter and transportation needs?**

_____

Employed Person	Company Name	Income (Pre- Tax)	Paid how often? (Check one)
		$	□ Weekly □ 2 times/month □ Monthly □ Every 2 weeks
		$	□ Weekly □ 2 times/month □ Monthly □ Every 2 weeks
Other Sources of Income:	Alimony $	TANF $	Pension/Retirement $
Unemployment $	Disability $	Social Security $	Immigration (I20 or J1) $
Profit/Loss Self Employ $	Other $	Other $	Other $

Household Information: List ALL individuals in your family, including the head of household.

Name	Date of Birth	Relationship	Insurance	Income	Employed
1.		**Self**	Yes/No	$	Yes/No
2.			Yes/No	$	Yes/No
3.			Yes/No	$	Yes/No
4.			Yes/No	$	Yes/No
5.			Yes/No	$	Yes/No
6.			Yes/No	$	Yes/No

Please make sure that you include your proof of income with this application.

-For office use only- D

Applied on: _____

HNP appt on:_____

Verified on:_____

Income: $ _____

Discount: _____%

○ **I AM REFUSING TO PARTICPATE IN THE DISCOUNT PROGRAM**

By signing below, I agree that VCHC staff may contact each employer listed and/or other agencies to confirm my income. I will provide VCHC with proof of income to calculate my discount. I will be asked to reapply for the program on an annual basis. I agree to inform VCHC of changes to my income, family size, or insurance coverage. I understand that certain services and/or items will not be discounted. **I agree to pay my nominal fee at each visit.** I hereby certify that the information I provide is correct.

Applicant Signature: _____ Date: _____