Lower Lights
Christian Health Center

Household Yearly Income

Date:

Patient Name:	**Social Security #:**	**Date of Birth:**
Address:	**Number:**	**Number:**

Sex: M / F **Marital Status: Single Married (Date: _____) Divorced Widowed Separated**

Ohio Resident? YES NO **Are you a US Citizen? YES NO** **Pregnant? NO NOT APPLICABLE YES (Due Date: _____)**

Household Information

Please complete the information below regarding your household number and income. Please note:
ALL household income must be reported to qualify for Medicaid or Sliding Fee programs.

Name of Household Member (claim on taxes)	Date of Birth	SSN	Source of Income (wages, SSI, disability, unemployment, child support, etc.)	Monthly Income Amount	How often paid?	Hours worked per week?	Currently receiving Medicaid?	Has been in foster care?	In school?

_____ _____

Signature Date

***MEDICAID/MARKETPLACE APPLICATION: If you would like our staff to assist you in applying for Medicaid or through the health insurance Marketplace, please read the below statement and sign at the bottom.**

I authorize Lower Lights Christian Health Center to apply for Medicaid/Marketplace on my behalf. I have voluntarily provided the above information, which is complete and truthful to the best of my knowledge.

_____ _____

Signature Date