The Health Center of Helping Hands
Sliding Scale Application

Date: ________________

Head of Household / Primary Income Earner:

______________________________ ______________________________ ____________________
Last name First name Middle name

Other names:____
If there are other names that you sometimes use (spouse's name, maiden name, etc.), please list those here.

Name of person completing application: ____

Street address: ____ Apt./Lot_______

City: ____ State: _________________

County: ____ Zip code: ______________

Home phone: ______________________ Other phones: ________________________

How long have you lived in Rockwall County? ________years ________months*

List ALL persons living in the family INCLUDING yourself:

NAME	M/F	Date of Birth	Age*	Social Security Number	Relationship	Legal Status
					SELF	

Legal Status: U. S. Citizen Resident Alien Temporary Resident Undocumented

***If you are a woman (ages 18-44) and are a US citizen, you are required to apply for the Women's Health Plan for your women's health needs (pap smears, birth control, etc). If you are not accepted to the WHP and submit your denial letter, then the SS will provide coverage for these needs.**

Application Completed? □Yes □No (why not?) ____

HEAD OF HOUSEHOLD / PRIMARY INCOME EARNER:

LAST NAME ______________________ FIRST NAME ______________________ MIDDLE NAME ______________________

MARITAL STATUS: ______MARRIED ______DIVORCED ______WIDOW(ER) ______OTHER

ETHNICITY: ______AFRICAN AMERICAN ______ ASIAN ______CAUCASIAN ______HISPANIC ______OTHER

RESIDENCY: ______US CITIZEN ______TEMPORARY RESIDENT ______RESIDENT ALIEN ______UNDOCUMENTED

INS NUMBER (IF APPLICABLE): ______________________________________

LANGUAGE: _______ENGLISH _______SPANISH _______OTHER

LIVING ARRANGEMENT: _____ALONE _____FAMILY _____ROOMMATE ______SPOUSE/OTHER ______HOMELESS

EMPLOYER/SCHOOL: ____

EMPLOYER'S ADDRESS:______________________________________ PHONE: ______________________

POSITION: ______________________________________ LAST DATE OF WORK/SCHOOL: __________________

DISABILITY: ______TOTAL/PERMANENT ______PARTIAL/PERMANENT ______TEMPORARY

INSURANCE: _____NONE _____EMPLOYER PAID _____ PRIVATE _____MEDICAID _____MEDICARE

****

SPOUSE:

LAST NAME ______________________ FIRST NAME ______________________ MIDDLE NAME ______________________

MARITAL STATUS: ______MARRIED ______DIVORCED ______WIDOW(ER) ______OTHER

ETHNICITY: ______AFRICAN AMERICAN ______ ASIAN ______CAUCASIAN ______HISPANIC ______OTHER

RESIDENCY: ______US CITIZEN ______TEMPORARY RESIDENT ______RESIDENT ALIEN ______UNDOCUMENTED

INS NUMBER (IF APPLICABLE): ______________________________________

LANGUAGE: _______ENGLISH _______SPANISH _______OTHER

LIVING ARRANGEMENT: _____ALONE _____FAMILY _____ROOMMATE ______SPOUSE/OTHER ______HOMELESS

EMPLOYER/SCHOOL: ____

EMPLOYER'S ADDRESS:______________________________________ PHONE: ______________________

POSITION: ______________________________________ LAST DATE OF WORK/SCHOOL: __________________

DISABILITY: ______TOTAL/PERMANENT ______PARTIAL/PERMANENT ______TEMPORARY

INSURANCE: _____NONE _____EMPLOYER PAID _____ PRIVATE _____MEDICAID _____MEDICARE

CURRENT FAMILY INCOME

SOURCE	MONTHLY	SPACE FOR STAFF USE
EARNINGS (LIST)		
SSI		
SSDI		
UNEMPLOYMENT BENEFITS		
WORKER'S COMPENSATION		
CHILD SUPPORT		
VETERAN'S BENEFITS		
TEMPORARY AID TO NEEDY FAMILIES (TANF)		
PENSION PLAN INCOME		
OTHER INCOME		
TOTAL INCOME	$	

What crisis led to the need for assistance?

Are you receiving food stamps? ___________ Monthly amount: ________________

List other government benefits that you receive: ____

____

I certify that the facts contained in this application are true and complete to the best of my knowledge. I understand that falsified statements on this application shall be grounds for denial of assistance. ___________ **(initials)**

I understand that the SS program benefits are for a limited time. I will have to re-apply to the program <u>prior</u> to the expiration date on my card. ___________ **(initials)**

I understand that dismissal of the SS program benefits are at the discretion of HCHH, and I can be dismissed from this program at any time if I abuse or misuse it. ___________ **(initials)**

I authorize the Health Center of Helping Hands to verify all documents and statements contained herein, and I authorize the references I provide to give any and all information concerning my employment, income, assets, benefits and any pertinent information they may have, personal or otherwise, to HCHH. I authorize HCHH to obtain /release information to/from any agencies involved in my application/request for Sliding Scale status for office visits.

____ ____________________

Name Date