Scenic Bluffs
COMMUNITY HEALTH CENTERS

HEALTHY NEIGHBOR PLAN APPLICATION

HEAD OF HOUSEHOLD

Last Name _____ First Name _____ Middle Initial___ Date of Birth _____

Mailing address_____ City/Town_____ State _____ Zip Code_____

County_____ Home Phone #_____ Cell Phone # (optional) _____

Single ❑ Married ❑ Include self, spouse and number of dependent children living at this address: _____

EMPLOYMENT STATUS

Head of household employed by_____

Address of employer_____

_____

Spouse employed by_____

Address of employer_____

_____

PLEASE PROVIDE PROOF OF MONTHLY INCOME

Examples: copies of most recent IRS 1040 form, 3 months of check stubs, or bank statements showing social security or disability income.

- ❑ Gross Wages_____
- ❑ Business Income_____
- ❑ Unemployment Income_____
- ❑ Social Security_____
- ❑ Disability Income_____
- ❑ Child Support (PAID TO YOU)_____
- ❑ Child Support (YOU PAY) _____
- ❑ Interest Income_____
- ❑ Other Income (ROTH IRA, 401K OR ALIMONY ETC.)_____
- ❑ None (PLEASE CONTACT FOR *NO INCOME FORM*)

Please list birth names and dates of birth for self, spouse, and dependent children living at above address:
Example: Sarah M. Jones, 2-16-1983

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

PLEASE *LIST AND PROVIDE PROOF* OF ANY MEDICAL PAYMENTS THAT AFFECT FINANCES:
Examples: medical insurance premiums paid out, regular payments on dental, medical bills and/or prescriptions.

_____
(TYPE) (AMOUNT $$)

_____
(TYPE) (AMOUNT $$)

I understand certain services and/or items cannot be discounted. I certify that the above is true and I authorize Scenic Bluffs Community Health Centers to verify any information. I agree to pay my account at the time of services.

X **SIGNATURE**_____ **DATE**_____

FOR OFFICE USE ONLY: _____New Certification _____Recertification (Previously HNP 1 2 3) Letter sent_____
___Approved at _____Discount _____Disapproved $_____ #_____
Accepted by_____ Date_____