CHI St. Joseph Children's Health

St. Joseph Access Plan Application

Application for Participation in the CHI St. Joseph Children's Health Discount Fee Program

Please complete all sections of this application. Failure to answer all questions and provide the requested verification documentation will result in delays in evaluating eligibility for the CHI St. Joseph Children's Health Discount Fee Program and/or denial of enrollment in the program. Please mark any question which does not apply with "N/A" signifying that the question is not applicable to your situation. If you have any questions or need assistance in completing the application please call 717.397.7625.

Patient Name: _____ Date of Birth: ___/___/_____

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(If this application is for more than two patients please include additional patient information on a separate sheet.)

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Parent/Guardian Name: _____

Home Phone: (____)____–_____ Mobile Phone (Parent/Guardian): (_____)_____–_____

Best Time to Contact: ◊ Morning (8AM to 12Noon) ◊ Afternoon (12noon to 5PM) ◊ Evening (5PM to 7PM)

E-mail Address: _____

Household Members

Please list all related members residing in your house. If more family members live in the household please attach an additional sheet of paper with the information for remaining members.

Name	Relationship	Date of Birth
	Patient	
	Parent/Guardian	

Application continues on back

Household Income

Household Wages / Earned Income			
Name	Amount	Frequency (Circle One)	Employer(s)
Parent/Guardian	$	Weekly Monthly Yearly	
Parent/Guardian	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other:	$	Weekly Monthly Yearly	
Total	$	Weekly Monthly Yearly	

Examples of Acceptable Income Verification Documents to be submitted with the application:

- Most Recent Federal Tax Return
- One Month of Pay Stubs
- Social Security Award Letter
- Bank Statements
- Employment Verification Letter documenting average pay per month

Please call CHI St. Joseph Children's Health (717.397.7625) if you have questions about appropriate income verification documents to be submitted with the application.

Certification

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions, may disqualify my family from further consideration for the discount fee program. I further agree to inform CHI St. Joseph Children's Health if there is a significant change in our income. If acceptance to the discount fee program is obtained under this application, we will comply with all rules and regulations of CHI St. Joseph Children's Health. I hereby acknowledge that I have read the foregoing disclosure and understand it.

Parent/Guardian Name: _____

Signature: _____ Date: ____/_____/_____

Mail along with Application to:
CHI St. Joseph Children's Health
1929 Lincoln Highway East, Suite 150
Lancaster, PA 17602