



Name of Head of Household _____ DOB _____ Phone: _____

Address: _____ City _____ State _____ Zip _____

Place of Employment _____

Work Phone: _____ Yearly Salary _____

Please list spouse and dependents:

Name	Date of Birth
Spouse _____	_____
Dependent _____	_____
Dependent _____	_____
Dependent _____	_____
Dependent _____	_____
Dependent _____	_____

Annual Household income

Gross Wages, Salaries, Tips, etc.	\$ _____
Social Security, Pension, Annuity, and Veterans Benefits	\$ _____
Alimony, Child Support, Military Family Allotments	\$ _____
Income from Business, Self-employment and Dependents	\$ _____
Rent, interest, dividend, and other	\$ _____
Total Income	\$ _____

Attach the following

Identification: (one of the following): Driver’s License, Birth Certificate, state identification

Income: most recent tax returns, 30 days’ Pay stubs **Bank statements:** checking and savings

I understand that the information, which I submit, is subject to verification by Helen Newberry Joy Hospital & Healthcare Center, and subject to review by federal/state enforcement agencies and other as required. I certify that the above information is a full, accurate description of the facts. Furthermore, I realize that HNJH to release /transfer information to the Community Health Access Coalition to facilitate the intake process.

Name (Print) _____

Signature _____ Date _____