MEMORIAL MEDICAL CENTER

COUNTY HEALTHCARE ASSISTANCE PROGRAM
(CHAP) APPLICATION FORM

MMC HOSPITAL: _____ CLINIC: _____ MED REC# _____

ACCOUNT #: _____ DATE OF SERVICE: _____

PATIENT NAME _____ SS#: _____

GUARANTOR NAME _____ REL TO PT _____

ADDRESS: _____ PHONE # _____

EMPLOYER _____

RESIDENT OF DONA ANA YES _____ NO _____ IF YES, HOW LONG? _____

HAVE YOU APPLIED FOR COMMUNITY BENEFIT PROGRAM YES___ NO ____ IF YES, WHEN: _____

DO YOU HAVE MEDICAL INSURANCE YES_____ NO_____ COMMENTS _____

HOUSEHOLD MEMBERS

NAME	RELATIONSHIP		DOB	SS#

TOTAL NUMBER OF HOUSEHOLD MEMBERS _____

HOUSEHOLD INCOME	SOURCE OF INCOME	MONTHLY AMOUNT BEFORE TAXES	VERIFICATION

TO INCLUDE EARNED INCOME, UNEMPLOYMENT BENEFITS, DISABILITY, CHILD SUPPORT,SOCIAL SECURITY,PUBLIC ASSISTANCE, EDUCATIONAL ASSISTANCE, FOOD STAMPS, EXTENDED FAMILY ASSISTANCE OR OTHER

TOTAL HH INCOME: _____ CB DISCOUNT _____

I HEREBY CERIFY THE ABOVE INFORMATION TO BE CORRECT AND I AM RESPONSIBLE FOR NOTIFYING MMC OF ANY CHANGES IN RESIDENTIAL AND/OR INCOME STATUS

SIGNATURE _____ DATE _____

WITNESS/NAME/TITLE _____ DATE _____

MANAGER/SUPERVISOR _____ DATE _____

CFO _____ DATE _____

**THIS DISCOUNT DOES NOT APPLY TO NEWBORN DELIVERY SERVICES