



Horizon Health Center Uninsured Care - Sliding Fee Application

Personal Information

Last Name	First Name	M.I.	Date of Birth (MM/DD/YYYY)	SS #
Home Address		City	State	Zip Code
Phone Number (Home) ()	Cell Phone Number ()			

Household Information

Marital Status: Single () Married () Separated () Divorced () Widowed ()	
Name of Spouse	Number of Adults in Home

Names of Children Under 18 in Home

Name	Date of Birth	Name	Date of Birth

General Information About the Applicant

Have you applied for Medicaid? Y N	Have you applied for Medicare? Y N
If denied Medicaid/Medicare, please give the reason:	
Do you have private health insurance? Y N	If yes, name insurance:
Do you have any of the following? Medicaid () NJ Family Care () SSI () Medicare () Medicaid HMO () Welfare ()	
Have you applied for disability? Y N	Were you denied disability income? Y N
Are you currently working? Y N	If no, are you on unemployment? Y N
Are you disabled? Y N	Do you live in a homeless shelter? Y N
Are you pregnant? Y N	Are you a minor student? Y N
Comments:	

Income Information

Select Income Pay Period:		
<input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		
What is your income per pay period? \$		
You must bring proof of income: Please circle what proof of income you have		
<table style="width: 100%;"> <tr> <td style="width: 50%;"> Recent Income Tax Return Unemployment Benefits Employer Statement Current Pay Stub </td> <td style="width: 50%;"> Food Stamp Verification Foster Care Child Support Social Security/Disability </td> </tr> </table>	Recent Income Tax Return Unemployment Benefits Employer Statement Current Pay Stub	Food Stamp Verification Foster Care Child Support Social Security/Disability
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