

For Office Use Only	
Date Rec'd _____	Initial _____
Computer date _____	Initial _____
Scanned date _____	Initial _____
Proof of Income rec'd date _____	
Further action needed: _____	

Eligibility Application for Medical and Dental Services

Thank you for your interest in the Catholic Charities Free Health Care Center (CCFHCC). To receive free medical or dental services, you must first be determined eligible for care. This is not a walk-in clinic. Volunteer doctors and dentists are only available by scheduled appointment. In order to be reviewed for eligibility, you must submit to CCFHCC the following information, plus proof of household income (see other side). Eligibility is re-evaluated annually.

Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone number(s) where you can be reached during the day or where we can leave a message. Be sure to include area code.

Home Phone _____ Work Phone _____

Cell Phone _____ Other _____

Do you have a job? ___No ___Yes: ___FT ___PT Employer _____

Are you a college student? ___No ___Yes. If yes, are you listed as a dependent? ___No ___Yes

Do you have medical coverage? ___No ___Yes

Do you have dental coverage? ___No ___Yes

Which of the following benefits have you applied for and received or been denied?

<u>Benefit Applied For</u>	<u>Rec'd</u>	<u>Denied</u>	<u>Benefit Applied For</u>	<u>Rec'd</u>	<u>Denied</u>
___ Medicare Part A	_____	_____	___ Unemployment	_____	_____
___ Medicare Part B	_____	_____	___ Strike Benefits	_____	_____
___ Medical Assistance	_____	_____	___ Social Security Insurance	_____	_____
___ Veterans Benefits	_____	_____	___ CHIP	_____	_____
___ Disability	_____	_____	___ Alimony	_____	_____
___ Adult Basic	_____	_____	___ Child Support	_____	_____
___ Work Comp	_____	_____			

Please list the people living in your household:

	<i>Name</i>	<i>Age</i>	<i>Relationship</i>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Continued . . .

Household Income

Household income includes all working individuals that reside in the home. Submit one of the following "proof of household income" for each working individual. If the name on the application is different from the name(s) on the proof of income, let us know how the documents are related.

- Recent pay stub with year-to-date (YTD) listed. If no YTD, then 4 recent pay stubs.
- Recent W-2 form.
- Recent tax return.
- Employer's verification of wages.
- If self-employed: recent tax return *and* Profit & Loss (P&L) statement.
- Letter from Social Security indicating benefits for the year.
- Medical Assistance (MA) denial letter.

What is your TOTAL GROSS HOUSEHOLD INCOME (before taxes)? You need fill out only one of the following:

Hourly \$ _____ Weekly \$ _____ Bi-Weekly \$ _____
 Monthly \$ _____ Yearly \$ _____

Federal Poverty Guidelines

Household incomes not exceeding 200% of the poverty level, based on Federal Poverty Guidelines, and who do not qualify for Medicaid or Medicare, may also be eligible for health services offered by Catholic Charities Free Health Care Center. The chart to the right shows maximum household incomes that are no greater than 200% of the poverty level.

Size of Family	Weekly Gross Income	Monthly Gross Income	Annual Gross Income
1	\$395	\$1,702	\$20,424
2	\$527	\$2,282	\$27,384
3	\$661	\$2,862	\$34,344
4	\$794	\$3,442	\$41,304
5	\$928	\$4,022	\$48,264
6	\$1,062	\$4,602	\$55,224
7	\$1,196	\$5,182	\$62,184
8	\$1,330	\$5,762	\$69,144
Each Additional Member	\$134	\$580	\$6,960

Catholic Charities Free Health Care Center Eligibility Review Process

Submit this Eligibility Application to CCFHCC along with Proof of Income(s) by mail, fax or in person. The Eligibility Application can also be completed over the phone.

Phone: 412-456-6911

Fax: 412-456-0128

Mail or in person:

Catholic Charities Free Health Care Center
 212 Ninth Street,
 Pittsburgh, PA 15222

Our Mission is to provide excellent primary health care at no cost if you are unable to afford adequate health insurance or are otherwise in need, regardless of religion.

You may also qualify for care if you have no coverage under any other health insurance plan for the services provided by CCFHCC and you meet income eligibility requirements.

Upon receipt of all of your information, your file will be reviewed for eligibility, normally within two weeks.

Questions? Call 412-456-6911.