Preventative Care Health Services, Inc.

Presidio County Medical Clinic
Ph 432-229-3030 Fx 432-229-3240
1501 N Erma Ave., PO Box 574
Presidio, TX 79845

Marfa Community Health Clinic
Ph 432-729-1800 Fx 432-729-1806
210 S. Summer St., PO Box 267
Marfa, TX 79843

Family Health Services of Alpine
Ph 432-837-4555 Fx 432-837-4556
1707 N. 4th St.
Alpine, TX 79830

PCHS

Application for Financial (Medical) Assistance Program. Good at PCHS Clinics ONLY

HOUSEHOLD COMPOSITION

Please Print Name of self, significant other and dependents **under age of 18** Date of birth Office use only: Eligibility

1. Name ______________________ DOB: __________ ☐ Yes ☐ No
2. Name ______________________ DOB: __________ ☐ Yes ☐ No
3. Name ______________________ DOB: __________ ☐ Yes ☐ No
4. Name ______________________ DOB: __________ ☐ Yes ☐ No
5. Name ______________________ DOB: __________ ☐ Yes ☐ No
6. Name ______________________ DOB: __________ ☐ Yes ☐ No
7. Name ______________________ DOB: __________ ☐ Yes ☐ No

Total number of eligible family members: __________

HOUSEHOLD INCOME (proof of income MUST be copied and attached)

Head of Household Name ______________________

Name of Employer/Self Employed: ______________________

Gross Wages per pay period: $ ______________________

How often are you paid? (Check one) ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

List other income from all sources, which may include self-employment wages, tips, unemployment benefits, social security, SSI, child support, military family allotments, pensions benefits, VA benefits, trust funds disbursements, training stipends, and all other forms of financial support. $__________ Source: ______________________

Name of Significant Other ______________________

Name of Employer/Self Employed: ______________________

Gross Wages per pay period: $ ______________________

How often are you paid? (Check one) ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

AFFIDAVIT

By signing below, I attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the family members listed are all solely dependent on that income, or that the explanation provided to verify my income level is truthful. I understand that I must provide proof of income at the time of service or I will be responsible for promptly paying the full charge of all visits.

APPLICANT SIGNATURE: ______________________ **Date:** __________

SLIDING SCALE DISCOUNT (FOR OFFICE USE ONLY)

PCHS SLIDING FEE CATEGORY: ☐ A ☐ B ☐ C ☐ D ☐ E

FAMILY ACCOUNT NAME: ______________________

VALID FROM: __________ (month/day/year) TO __________ (month/day/year) ______________________ (Authorized Office Staff Signature)