

New Enrollment  Reenrollment

**Partners' CAP - Application for Discounted Health Services** Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
                    First                    Middle                    Last                    Gender: \_\_\_F \_\_\_M

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ ZIP: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Employer, Name and Address: \_\_\_\_\_

**Household Information:**

Persons living with you: Spouse \_\_\_ Number of Children \_\_\_ Number of Relatives & Others \_\_\_  
(Must be updated at re-enrollment)

**Total Number of persons living with you:** \_\_\_\_\_

**Monthly Income:**

List the monthly income sources and amounts for all people in your household (Must be updated at re-enrollment)  
(Add more on another page, if necessary):

Income Source	Gross Amount (before any withhold)
1.)	\$
2.)	\$
3.)	\$
<b>Total Monthly Income:</b>	\$

**Verification Method:** Employer Payroll stubs \_\_\_ Income tax return \_\_\_ Other \_\_\_  
(Keep a copy of proof of income) (Must be updated at re-enrollment)

**Assets** (Give value of the following household assets) (Must be updated at re-enrollment)

Checking account: \$ \_\_\_\_\_ Savings account: \$ \_\_\_\_\_

Stocks/Bonds/Investments: List: \_\_\_\_\_

Real Estate: If owned, Value \$ \_\_\_\_\_ Mortgage Remaining: \$ \_\_\_\_\_

Cars: #1 \_\_\_\_\_ \$ \_\_\_\_\_ #2 \_\_\_\_\_ \$ \_\_\_\_\_  
                    Make & Model                    Year                    Value                    Make & Model                    Year                    Value

Recreational Equipment (boat, motorcycle, campers) List: \_\_\_\_\_

**Total Value of Assets: \$** \_\_\_\_\_

**Certification**

*I hereby certify that the financial information given by me is correct to my best knowledge and belief.  
I approve the transfer of the information recorded on this form to the CAMC Patient Financial Statement.  
I have received an explanation of the Partners CAP benefits and responsibilities.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness Initial \_\_\_\_\_

**Staff Complete Below:**

*(See the Table of Income Levels and Family Size on reverse side, along with clinic instructions.)*

Eligible for CAP (gross income below 200% FPL): \_\_\_ Yes \_\_\_ No Sliding Fee Level: \_\_\_\_\_

Eligible for CAMC services (gross income < 200% FPL and assets not exceed \$50,000) \_\_\_ Yes \_\_\_ No

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Entered into CAPgate? \_\_\_ Yes \_\_\_ No

Origin of Application (Name of clinic): \_\_\_\_\_ Submitted by: \_\_\_\_\_