



Section I: PATIENT/APPLICANT

Experiencing Homelessness

Today's Date: _____

Effective Date: _____

End Date: _____

First Name _____	Middle Initial _____	Last Name _____	
Address _____		City _____	
Zip Code _____	County _____	Phone Number _____	

List Household Members	Relationship to Patient	Date of Birth	Health First CO/CHP+ Number	Household Member Approved for:
1. _____	PATIENT/APPLICANT	_____	_____	Hosp Disc Care/Charity Care
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____
15. _____	_____	_____	_____	_____

Section II: Calculating Income

Income Source	Monthly Income	Annualized Total
1. Gross Employment Income	\$0.00	\$0.00
2. Unearned Income	\$0.00	\$0.00
3. Self-Employment Income	\$0.00	\$0.00
4. Total Income (Lines 1 + 2 + 3)	\$0.00	\$0.00
5. Deductions (See Worksheet 3)	\$0.00	
6. Grand Total Annual Income	\$0.00	

FPG Percentage: 0 Household Size 1

Facility Monthly Max.: \$0

Physician Monthly Max.: \$0

