Date: ____________________

Mental Health Copay Assistance Program

128 E. Grant St., Ste. 104 Lancaster, PA 17602
Phone: 717-392-1595 FAX: 717-397-8723

ENROLLMENT APPLICATION

Please complete a separate application for each person applying

Last Name, First MI			Social Security Number
Address	**City**	**State**	**Zip Code**
Home Phone	**Work Phone**	**Cell Phone**	
Date of Birth	**Emergency Contact Name and Phone**		

1. Referred by ____

2. Are you applying for or receiving Supplemental Security Income (SSI)? _____Yes ______No

3. Do you have Medical Assistance through the Welfare Office? _____Yes ______No
   If no, did you have Medical Assistance in the last 6 months? ____Yes ______No
   If yes, reason for termination ____

4. Do you have a Medical Assistance application pending? ____Yes ______No
   If yes, what date did you submit the application? ________________________________

5. Do you have any other type of health insurance? _____Yes _____No

6. Do you have Medicare through Social Security? ____Yes _____No

7. Are you a veteran? _____Yes _____No
   If yes, do you receive Veterans' Benefits? _____Yes _____No

8. Are you a spouse or widow of veteran? _____Yes _____No
   If yes, do you receive Veterans' Benefits? _____Yes _____No

9. What is your citizen status?
   U.S. Citizen_____ Permanent Alien ____Temp. Alien_____ Refugee/Asylee ___Other_____

10. Do you have a medical problem that keeps you from getting or keeping a job? _____ Yes ______No

11. Are you applying for or receiving Social Security Disability? _____Yes _____No
    If you are receiving Social Security Disability, what is the date your benefits began? ______________

12. What is your monthly gross income from all sources? $__________________

13. What is your family size? ________

14. What is your marital Status? Married__Single _____Widow/Widower____Divorced_____Other______

15. Do you have children under 21 living in the home? ______Yes ______No
    If no, are your resources (cash, bank accounts, IRA's, etc.) less than $2000? ______Yes ______No

16. Are you or anyone who lives with you pregnant? ______Yes ______No

17. Do you require health-sustaining medications? ______Yes ______No

18. Do you have any unpaid medical bills from the last 3 months? ______Yes ______No
    If yes, what is the approximate dollar amount? $___________

19. Who is your primary care physician? Practice and site ____

    ____

20. Have you lived in Lancaster County for more than 3 months? ______Yes ______No

21. Race/Ethnicity: (optional)
    African/American _______Asian/Pacific Islander ______Caucasian _______ Hispanic _______Other _______

22. What language do you prefer? ____

23. List barriers to appointments with providers (i.e. outstanding bills, termination, lack of transportation, no English spoken, etc.) ____

    ____

24. Are you employed? Yes______No______ If yes, where? ____

    If no, date of last employment ____

25. Does your work place offer health Insurance? ______Yes ______No
    If yes, how much would it cost per month? $________

26. Translator needed? ______Yes ______No

27. Transportation needed? ______Yes ______No

Income: List amount of monthly gross income (before taxes and deductions):

	Salary/ Wages	Social Security / SSI	Disability	Unemployment	Worker's Comp	Pension/ Retirement	Self-employment	Child Support/ Alimony	Other Income
Self	$	$	$	$	$	$	$	$	$
Spouse	$	$	$	$	$	$	$	$	$
Child (under 18)	$	$	$	$	$	$	$	$	$
Child (under 18)	$	$	$	$	$	$	$	$	$
Other	$	$	$	$	$	$	$	$	$

Total Gross Income $_____________

Total in Checking/Savings $______________

If no income, please explain how your basic needs are being met ________________________________

____

HOUSEHOLD INFORMATION

Last name, First Name, MI	Are you applying for this person?	Sex	Date of Birth	Marital Status	Social Security Number	Relation to Applicant	Citizenship Status	Lived in Lancaster County for more than 3 months?

Please attach to this application a copy of your identification, proof of residency, and proof of income. Acceptable IDs and proofs are listed on the attachment.

YOUR APPLICATION CANNOT BE COMPLETED WITHOUT THESE DOCUMENTS.

I certify that the above information is a full and complete disclosure of my income and address.
I certify that the above information is true to the best of my knowledge and there is no attempt to commit fraud. I understand that appropriate action will be taken if the above information is found to be false.

Applicant signature	Date

Acceptable Proofs of Income (provide one document for each type of income for your **monthly** gross income)

- Copy of pay stubs, checks, and award letters from the last 30 days
- Employer's written statement including employer's name, address, and phone number and how much was earned during the last 30 days
- Copy of Social Security award letter, current check, or direct deposit record in bank statement
- Copy of Worker's Comp check, check stub or current award notice
- Copy of award statement for unemployment
- Copy of pension check or statement
- Copy of bank statement showing interest for bank accounts
- Copy of proof of income from educational loans or grants
- A written statement from a person or agency providing money or making payments for you.
- If you are self-employed we need both, your estimated income and expenses for the last quarter of the current year, typed in a company's cover letter, signed and dated, and a copy of last year's federal tax return
- Copy of last year's federal tax return