

KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
 Office of Local and Rural Health
Charitable Health Care Provider Program

Certification of Eligibility

Head of Household

(optional) _____, _____ MI
 Last name(s), First MI

**Eligibility
Form C**

TODAY'S PATIENT, or (optional, list all family members who may become patients)

_____, _____ MI
 Last name(s), First MI

_____, _____ MI

_____, _____ MI

_____, _____ MI

_____, _____ MI

_____, _____ MI

_____, _____ MI

1. Our total family income is per (Circle one) year month hour

2. How many individuals are supported by this income?

3. If you have any of the following health coverages, please check.

Medicare **Medicaid**
HealthWave **Blue Cross** **Other** or I have no health insurance

This information is correct and I provide it in order to receive care under the Charitable Health Care Provider Program. (KSA)75-6120

*Signature of Applicant
 or Parent or Guardian of Applicant*

Date

DIRECTIONS for Staff:

1. Select either the annual, monthly or hourly income from the **Income Eligibility Chart**
2. Find the number in the first column that shows the number of persons supported by total family income
3. From family size number, move right along the line to find the income range that includes the total income for all the workers in the family.
4. Find the income range at the top of the column and mark below
 - < 100% FPL
 - 100-149% FPL
 - 150-174% FPL
 - 175-200% FPL
 - > 200% FPL