W.V.H.A. HEALTH CARD APPLICATION

Phone Number: 386-232-2055

DELTONA: **THE HOUSE NEXT DOOR**
840 DELTONA BLVD Suite K (JUSTIN SQUARE)
****MONDAY-THURSDAY* ***9:00am-5:00pm***
****FRIDAY* ***9:00am-2:00pm***
BY APPOINTMENT ONLY

TRISH BRITO GRAW..... ext 1122
TBRITO-GRAW@THEHND.COM

ANGELICA GONZALEZ ..... ext 3206
AGONZALEZ@THEHND.COM

DELAND: **THE HOUSE NEXT DOOR**
114 S. ALABAMA AVE. DELAND 32720
****MONDAY-THURSDAY* ***9:00am-5:00pm***
****FRIDAY* ***9:00am-2:00pm***
BY APPOINTMENT ONLY

MARISOL ESTRADA..... ext 1109
MESTRADA@THEHND.COM

TO EXPEDITE THE PROCESS, PLEASE APPLY FOR THE AFFORDABLE HEALTH CARE ACT (OBAMA CARE) AND BRING RESULTS WITH YOU. It is required for this application.
WWW.HEALTHCARE.GOV
(800)318-2596

The House Next Door
Nurturing Families. Building Communities.

Nurturing Families
Building Communities

What do YOU Need?

2 Forms of ID
1 Picture ID & 1 of the following:
SS Card, Birth Cert, Passport, Farmworkers ID

Do you OWN, RENT LIVE in SOMEONE else's house or are HOMELESS?
YOU Will NEED ALL the following

OWN

- ✓ Property Tax Bill OR Mortgage Payments
- ✓ Last 3 Months of Mail (1 x month that shows Name, Address & Date)

OR

- ✓ Property Tax Bill OR Mortgage Payments
- ✓ Current Vehicle Registration

RENT

- ✓ Copy of CURRENT Lease OR Rent **VERIFICATION** Form
- ✓ Last 3 Months of Mail (1 x month that shows Name, Address & Date)

OR

- ✓ Copy of CURRENT Lease OR Rent **VERIFICATION** Form
- ✓ Current Vehicle Registration

Live with SOMEONE

- ✓ Verification of **SUPPORT** Form
- ✓ Last 3 Months of Mail (1 x month that shows Name, Address & Date)

OR

- ✓ Verification Of **SUPPORT** Form
- ✓ Current Vehicle Registration

Homeless

- ✓ Homeless Verification Form **From** Neighborhood Center (DELAND)

Or

New Hope Life Center (DELTONA)

What Is YOUR Income?

- o Last 8 Weeks PAYSTUBS
- o Self Employed
- o Notarized Verification of Support
- o Social Security Benefit
- o Retirement
- o Alimony/Child Support
- o Food Stamps
- o Other

What are YOUR Assets?

- o Bank Statements for the last 3 MONTHS for **ALL** Accounts (**ALL Pages**)
- o RVS/TRUSTS/STOCKS/BONDS and Other Investment Income

EVERYONE NEEDS 1 of the Following

- o ACA Affordable Care Act Eligibility Results
- o (Non-Citizen) - FARMWORKERS ASSOCIATION LETTER
- o DACA Letter and ID

WVHA HEALTH CARD APPLICATION

Application Date:	

Section 1: Applicant Information. All members of Household may apply through the same application. Please indicate all applicants in Section 2 'Members of the Household'.

Last	First	Middle	Maiden or Other Name

Physical Address (where you reside)			

City	County	State	Zip

Mailing Address			

City	State	Zip

How long have you lived at residence?	Temp/Perm	Rent/Own/Other	Daytime Telephone	Evening Telephone

Date of Birth	Sex (circle one) Male Female	Social Security Number

Previous address if less than 3 months		

City	State	Zip

Section 2: Members of the Household List legal spouse, dependent children, stepchildren, adopted children, unrelated minor with proof of custody, children over 18 up to 24 years old that are full time students and claimed on parent's income taxes as dependents.

Name	Applying for Health Card	DOB	Relationship	SS#
1.	Yes No (circle one)			
2.	Yes No (circle one)			
3.	Yes No (circle one)			
4.	Yes No (circle one)			
5.	Yes No (circle one)			
6.	Yes No (circle one)			
7.	Yes No (circle one)			
8.	Yes No (circle one)			

Section 3: Authorization to Release Medical and Individually-Identifiable Protected Health Information (PHI).

All Applicants over 18 must sign below or application will be pended.

I on my behalf and on behalf of any applying family member under the age of 18, do hereby authorize West Volusia Hospital Authority (WVHA), Northeast Florida Health Services, Inc. (NFHS), and any of their successors and/or assigns and any of their independent sub-contractors and participating providers, to release and exchange any and all data, records and information related to medical records and individually identifiable protected health information (PHI) in their respective capacities as covered entities under HIPAA, and as allowable under federal and state laws, including but not limited to the data, records and information as necessary to provide care and/or administer the WVHA Indigent Health Card Program.

I hereby waive, relinquish and release the organizations referenced above, who have been granted the authority to release information to each other and otherwise, from any and all claims arising out of my authorization to release this information in accordance with the terms of this document.

A photocopy of this Authorization is considered as valid as the original. You are entitled to make and return a photocopy of this authorization. The authorization referenced above in regards to medical records shall remain in effect indefinitely unless property terminated by written notice.

I certify that the information given by me for the purpose of qualifying for the WVHA Health Card Program is true and correct. I understand and hereby authorize WVHA and its agents to conduct such investigation, including, but not limited to obtaining my credit report, as necessary to verify the accuracy of the information provided. I understand that any misrepresentation by evidence of submission or omission may result in my termination from the WVHA Health Card Program.

Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date

WVHA HEALTH CARD ASSESSMENT FORM

Screened by
(THND Representative):_____

Instructions: Please complete this form in its entirety. This form must be completed by all applicants over 18, including legal spouses who are not applying. *Failure to provide separate WVHA Health Card Assessment Forms will results in a Pended application.*

Section 1: General Information.

Date	Applicant Name	Date of Birth	Clinic

How did you hear about the WVHA Health Card Program? Check one box:

☐ WVHA Webpage ☐ Printed advertisement or flyer ☐ Public meeting ☐ Florida Hospital ☐ The House Next Door
☐ Rising Against All Odds ☐ The Neighborhood Center ☐ Healthy Start ☐ Hispanic Health ☐ Other

Section 2: Insurance Information.

2.1 Do you have any Medical Insurance?	☐ Yes *If Yes, please indicate Carrier and ID #:* _____	☐ No
2.2 Are you eligible for COBRA Benefits from a current/prior employer?	☐ Yes	☐ No
2.3 Do you have Medicare A or B?	☐ Yes *If Yes, please indicate which coverage you are enrolled in & effective date* _____	☐ No
2.4 Do receive healthcare assistance or aid other than WVHA?	☐ Yes *If Yes, please indicate the assistance and/or aid you receive & effective date* _____	☐ No
2.5 If you are seeking services for an injury, is your injury due to a work related or auto accident?	☐ Yes *If Yes, please describe* _____	☐ No

2.6 Proof of Medicaid application or denial is required. Please ensure to include this with your submission

Section 3: Family Size.

3.1 Marital Status (Circle One): Married Separated Divorced Single Widow

3.2 Do you have any dependent children living in the household?	☐ Yes *If Yes, how many?* _____	☐ No

Section 4: Identification.

4.1 Do you have a Driver License or other Government ID?	☐ Yes *If Yes, please provide a copy of ID*	☐ No

4.2 Two (2) forms of ID are required, one (1) must be a picture ID. Please circle any other proof of identification provided other than a Driver License.

Non-Picture ID:	Picture ID:
-Social Security Card	-Passport
-Birth Certificate	-Green Card
-Certificate or Official Document w/ Name, Address, & SSN	-Form I-151
	-Form I-551
	-Farmworkers Association of Florida-Photo ID

Section 5: Residency

5.1 Do you own the house where you live?	☐ Yes *If Yes, please provide Property Tax Bill of current or prior year*	☐ No
5.2 Do you rent?	☐ Yes *If Yes, please provide a copy of current Lease Contract or Verification of Rent Form*	☐ No
5.3 Do you live in someone else's house?	☐ Yes *If Yes, please provide Verification of Support Form*	☐ No
5.4 Do you consider yourself homeless?	☐ Yes *If Yes, please provide Homeless Verification Form*	☐ No

5.5 All proof of residency documents must show street address within the WVHA Tax District and must be for the past immediate 3 months. Two (2) forms of residency are required, unless you are homeless applicant. Homeless applications only need to submit the Homeless Verification Form.

Please circle any other proof of residency provided:

- Utility Bills (Electric, Water, Telephone, Gas, etc.)
- Mail received for three (3) month period
- Vehicle Registration in the applicant/spouse's name
- Mortgage Payment
- Proof of children registered in West Volusia School

Section 6: Financial Information

6.1 Have you been employed in the last 8 weeks?	☐ Yes *If Yes, complete the below & provide previous 8 weeks worth of paystubs or DCF Verification of Employment/Loss of Income Form*	☐ No

Employer Name	Pay Rate (circle one) Hourly Daily Weekly Biweekly Monthly
Employer Address	

City	State	Zip

6.2 Have you lost your job in the last 8 weeks?	☐ Yes *If Yes, please provide a DCF Verification of Employment/Loss of Income Form*	☐ No
6.3 Are you self-employed?	☐ Yes *If Yes, please provide most recent tax return (complete with all schedules/forms) or self-employment quarterly statement*	☐ No
6.4 Are you receiving Unemployment or Worker's Comp benefits?	☐ Yes *If Yes, please provide Unemployment or Worker's Comp Documents*	☐ No
6.5 Is someone else supporting you financially?	☐ Yes *If Yes, please provide notarized Verification of Support Form*	☐ No
6.6 Do you receive Veteran or Military Benefits?	☐ Yes *If Yes, please provide benefits paperwork*	☐ No
6.7 Do you receive any settlements?	☐ Yes *If Yes, please provide settlement paperwork*	☐ No
6.8 Do you receive Food Stamps?	☐ Yes *If Yes, please provide supporting documentation from Florida DCF along with approved amount.*	☐ No
6.9 Are you receiving any monthly Pension or Retirement Income?	☐ Yes *If Yes, please provide documentation with amount you receive, if applicable*	☐ No
6.10 Do you receive Alimony/Child Support Income?	☐ Yes *If Yes, please provide documentation with amount you receive, if applicable*	☐ No
6.11 Do you receive any income from rental properties?	☐ Yes *If Yes, please provide rental income amount and rental agreement*	☐ No
6.12 Do you receive Social Security Income/Disability Benefits?	☐ Yes *If Yes, please provide supporting documentation*	☐ No

Section 7: List All Sources of Income for the Household (i.e. Temporary Assistance for Needy Families, Strike Benefits, Insurance/Annuity Income, Dividend/Interest Earning, Training Stipends, Compensation for Injury/Settlement, Gifts from Churches/family/organizations, etc.) Please provide all supporting documentation for any income listed below.

Individual's Name	Type of Income	Source of Income or Employer	Monthly Amount (before deductions)

Section 8: Assets

8.1 Do you have a checking/savings account?	☐ Yes *If Yes, please provide copy of statements for all the accounts for last 3 months*	☐ No
8.2 Do you own a Business?	☐ Yes *If Yes, please provide last Quarter Business Financial Statements and Bank Statements*	☐ No
8.3 Do you own property(ies) in other counties/states or country (including rental properties that you own)?	☐ Yes *If Yes, please list all the properties you own below, including lots, & provide any outstanding mortgage documentation outside of your permanent residence*	☐ No

Property Address	Is this a rental property? ☐ Yes	☐ No
Property Address	Is this a rental property? ☐ Yes	☐ No
Property Address	Is this a rental property? ☐ Yes	☐ No

8.4 Have you sold or transferred title to any property in the last 3 years?	☐ Yes *If Yes, please list all the properties, including lots and supply supporting documentation as proof of this sale*		☐ No
Property Address	Date of Sale: ___/___/_____	Is this a rental property? ☐ Yes	☐ No
Property Address	Date of Sale: ___/___/_____	Is this a rental property? ☐ Yes	☐ No
Property Address	Date of Sale: ___/___/_____	Is this a rental property? ☐ Yes	☐ No
8.5 How many automobiles, motorized vehicles or motorcycles do you own? Single automobile should only be recorded on one applicant's assessment form	_____ *For two or more vehicles also include the value as determined by N.A.D.A book along with vehicle(s) registration.*		
8.6 Do you own any recreational vehicles?	☐ Yes *If you do own, please provide vehicle(s) registration along with the value determined by a statement from a commercial seller of such vehicle(s)*		☐ No

Section 9: List All Sources of Assets for the Household (i.e. IRAs, CDs, Inheritances, pensions, stocks, trust funds, cash surrender value of life insurance, etc.). Please provide all supporting documentation for any assets listed below.

Asset Type	Source of Asset	Amount	Monthly or Lump Sum	
			☐ Monthly	☐ Lump Sum
			☐ Monthly	☐ Lump Sum
			☐ Monthly	☐ Lump Sum
			☐ Monthly	☐ Lump Sum
			☐ Monthly	☐ Lump Sum

Section 10: Applicant Certification

I certify that the information given by me for the purpose of qualifying for the WVHA Health Card Program is true and correct. I understand and hereby authorize WVHA and its agents to conduct such investigation, including, but not limited to obtaining my credit report, as necessary and at any time during the application process, enrollment or after benefits have been assigned to verify the accuracy of the information provided. I understand that any misrepresentation by evidence of submission or omission may result in my termination from the WVHA Health Card Program.

Signature of Individual or Legal Representative	Date

Proof of Identification

Please check the 2 pieces of ID attached:

(Id has to be current)

a. Birth Certificate ☐

b. Florida Driver's License/Identification Card With WVHA Address ☐

c. Social Security Card ☐

d. Farmworker Association of Florida- Photo ID with correct address ☐

e. Passport ☐

f. Certificate or Official Document that includes name, address, and social security number (i.e., tax form or social security document) ☐

g. Alien Registration Receipt Card (Green Card, Form I-151 or I-551) ☐

h. Any government issued photo identification ☐

Article VIII WVHA Residency – Section 8

Proof of Residency

Please check documents included:

The applicant must reside in WVHA Taxing District. Except for those qualified as "homeless", residence exist when the applicant has lived within the WVHA Taxing District and has been a permanent resident for a minimum of three (3) months.

- Property Tax Bill ☐
- WVHA Rent Verification (Appendix H) ☐
- Lease, Housing, rent/mortgage agreements/receipts ☐
- Utility Bills - Electric, water, telephone, gas, or other city or County utilities (3 months) ☐
- WVHA Verification of Support (Appendix G) if the applicant is living with another party
  Shelter Verification Form- Enrolled in a facility or agency program (Appendix F) (Accompanied by proof of residency 3months prior to enrollment – Homeless only 1 month) ☐
- Vehicle Registration in the name of the applicant/spouse ☐
- Proof of children registered in area schools ☐
- Mail received by applicant in West Volusia County for three (3) months. If mail sent to a P.O. Box, the applicants' physical address must be noted in document. ☐

WVHA Verification of Rent

Instructions: Please complete this form in its entirety. *Failure to provide all information on Verification of Rent Form will result in a Pended application.*

Section 1: General Information.

Date:	Applicant Name:	Date of Birth:	Last Four Digits of SSN:

Section 2: I am presently residing at.

Physical Address

City	County	State	Zip

2.1 The monthly rent is $_____.

2.2 I began renting at the above location on the following date _____.

Applicant Signature	Date

Section 3: Rentor/Lessor Information. Must be completed by the Rentor/Lessor

Rentor/Lessor Name	Rentor/Lessor Phone Number

Rentor/Lessor Address

City	State	Zip

Relationship to Tenant

Tenant Name

3.1 I am renting the address listed above in Section 2 to the applicant since _____ (date).

3.2 The current monthly rental rate is $_____.

3.3 The monthly rent does / does not (circle one) include utilities.	**3.4** If yes, list utilities included.

Section 4: Rentor/Lessor Signature

I, the undersigned, do hereby swear that the information contained herein is true and correct.

Rentor/Lessor Signature	Date

"A UNITED WAY AGENCY"

Neighborhood Center of West Volusia, Inc.

"A PLACE WITH A HEART"

434 South Woodland Blvd, DeLand, FL 32720
Phone: (386)734-8120 – Fax: (386)822-9005
neighborhoodcenterwv.org

WVHA Homeless Verification Form

Agency Instructions: *To be printed on Agency letterhead.* Please complete this form in its entirety.
Failure to provide all information on Homeless Verification Form will result in a Pended application.

Section 1: General Information

Date	Client Name	Date of Birth	Photo ID Number

Section 2: Mailing Address

Mailing Address (where your WVHA Health Card correspondences should be mailed)

City	County	State	Zip

Length of time in Volusia County

Section 3: Agency Assessment

I, _____, based on my assessment certify that the client has met the H.U.D. definition of homeless and has been within the West Volusia Tax District for at least one month.

Agency Signature:	Date:
Client Signature:	Date:

Proof of Income

Amount of Members in your household: _____ Estimate Monthly Income Amount: _____

(Only count legal spouse, dependent children, stepchildren, adopted children, partner's children, unrelated minor with proof of custody, children over 18 and 24 years old that are full time students and claimed on parent's income taxes as dependents)

Please select Proof of Income Documents:

- Wages, salaries and gratuities, Pay Stubs for previous 8 weeks ☐
- Social Security benefits for any household member ☐
- Supplemental Social Security Income (SSI) or Disability Benefits SSI ☐
- Temporary Assistance for Needy Families (TANF) ☐
- Retirement or Pension Benefits, Stocks, Bonds, and Annuities ☐
- Royalties and Rents/Income from Rental Property ☐
- Unemployment/Worker's Comp Statement ☐
- Veterans or Military Benefits/Allotments ☐
- Strike Benefits ☐
- Insurance and Annuity Income ☐
- Dividends and Interest Earnings (stocks, bonds, etc.) ☐
- Estate and Trust Fund Income ☐
- Private Loans of a Recurring Nature ☐
- Training Stipends ☐
- Alimony/Child Support ☐
- Inheritance ☐
- Compensation for an Injury/Settlements - Any settlements, court ordered or otherwise ☐

WVHA Verification of Support

Instructions: Please complete this form in its entirety. *Failure to provide all information on Verification of Support Form will result in a Pended application.*

Section 1: General Information.

Date	Applicant Name	Date of Birth	Last Four Digits of SSN

Section 2: I am presently residing at.

Physical Address			
City	County	State	Zip

I have been residing at the above address since: _____

Section 3: My previous address was.

Address			
City	County	State	Zip

I lived at this previous address for: _____

Section 4: My food and/or living expenses are provided by.

Provider Name	
Applicant Signature	Date

Section 5: To be completed by Provider.

5.1 Do you only provide a place to stay (rent free) and no monthly expenses are provided to the applicant?	☐ Yes	☐ No
5.2 Does the applicant reside with you?	☐ Yes	☐ No

INSTRUCTIONS FOR QUESTIONS 5.3, 5.4, AND 5.5

- The amount listed below should be the household expenses for where the applicant resides.
- If the provider pays for household expenses on behalf of the applicant (even if they live in separate homes) the dollar amount must be listed here. Question 5.4 would then indicate the qualified family members on the WVHA Health Card application that the provider is supporting.
- If the provider DOES NOT pay for household expenses on behalf of the applicant, please indicate $0 or N/A on 5.3 and 5.4

5.3 Total monthly household expenses covering all residents (rent, electric, water, groceries, etc.) $_____

5.4 Total number of people residing in household (including the applicant) _____

5.5 In addition to the monthly household expenses, I provide $_____ per month to the applicant.

Provider Name	Relationship to Applicant	
Provider Address		City
State	Zip	Provider Phone No.

Section 6: Provider Signature & Notary.

I, the undersigned, being responsible for the named applicant, do hereby swear that the information contained herein is true and correct, and that I am providing support for named applicant.

Provider Signature:	Date:
Notary Public	

WVHA Health Card: Self Employment Quarterly Statement

Instructions: Please complete this form in its entirety. This form must be completed if you are self-employed and do not make enough to file on income taxes. *Failure to provide all information on the form will result in a Pended application.*

1. **APPLICANT'S NAME:** (First) (M.I.) (Last)
2. **APPLICANT'S PERCENTAGE OF OWNERSHIP IN THIS BUSINESS:** _____%
3. **BUSINESS OWNER NAME(S)** (First) (M.I.) (Last)
4. **BUSINESS NAME:**
5. **BUSINESS ADDRESS:**
6. **BUSINESS PHONE #**

Section 1: -Total Gross Income- Add total monthly income and sales from your business each of the past 3 months.	**MONTH 1** _____/_____ (MM) (YY)	**MONTH 2** _____/_____ (MM) (YY)	**MONTH 3** _____/_____ (MM) (YY)
	1A: $	2A: $	3A: $
Section 2: Business Expenses	**DEDUCTIONS**	**DEDUCTIONS**	**DEDUCTIONS**
Supplies	$	$	$
Heat/Utilities/Phone			
Business property rent			
Business Equipment Rent			
Business Vehicle Expenses			
Business Taxes			
Advertising			
Insurance			
Bank Charges			
Other (specify)			
TOTAL Business Expenses	1B: $	2B: $	3B: $
NET INCOME: Subtract A FROM B = C	1C: $ (1A minus 1B)	2C: $ (2A minus 2B)	3C: $ (3A minus 3C)

Section 3: Calculate average monthly income

TOTAL 3 MONTHS: $_____ (ADD 1C, 2C, 3C)

AVERAGE 3 MONTHS: $_____ (DIVIDE TOTAL 3 MONTHS BY 3)

APPLICANT SIGNATURE: Applicants must read and sign the below

I certify that I have no other way to document the above self-employment income and that all of the above information is true and correct. I attest that all income and expenses on this form are truly for my self-employment business.

Signature **Date**

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

VERIFICATION OF EMPLOYMENT/LOSS OF INCOME

Date: _____

_____

_____

_____

In order to determine the eligibility of _____ for public assistance, please assist us by answering the questions below and returning this form to us by _____.

_____
Case Name

_____
Case Number/Cat/Seq./SSN

Office Address / Phone Number:
The House Next Door
804 N Woodland Blvd
DeLand, FL 32720
FAX: 386-734-0252

Please complete each section which has been marked on PAGE 1 and PAGE 2 of this form.

☑ **Section I – GENERAL INFORMATION**

1. Name of Employee:_____ Social Security Number:_____
   Address:_____
2. Job Title:_____ Type of Work Performed:_____
3. Number of Hours Worked Per Week:_____ Number of Days Worked Per Week:_____
4. A. How often is/was the employee paid? ☐ Day ☐ Week ☐ Bi-Weekly ☐ Monthly
   B. Rate of pay: $_____ per _____ (Hr./Day/Wk./etc.). ☐ Other _____ (Explain)
5. Date current employment began:_____ Date previously employed:_____
6. Does/did employee receive tips? ☐ Yes ☐ No ***(If yes, please show tips in Section III.)***
7. Is/was employment seasonal? ☐ Yes ☐ No If yes, season begins:_____ ends:_____
8. Is/was the employee covered by health insurance? ☐ Yes ☐ No
   If yes, name of insurance company:_____
9. Number of dependents covered:_____
10. Does/did the employee participate in any type of payroll savings plan or profit sharing? ☐ Yes ☐ No
    If yes, what is the balance? $_____
11. Does the person perform their job duties: ☐ in their home ☐ in your home ☐ N/A

☐ **Section II – LOSS OF INCOME**

1. Date employment ended:_____
2. Reason for termination:_____
3. Is the loss of income ☐ Permanent or ☐ Temporary? If temporary, when do you expect the employee to return to work? _____
4. Date employee received final check:_____ Gross amount: $_____
   (Please list last 8 weeks in Section III.)
5. Will employee receive any vacation pay, retirement refund, or other? ☐ Yes ☐ No
   If yes, what type? _____ Date received:_____ Amount: $_____
6. Is employee eligible for any type of benefits from your company, such as extended insurance coverage, workers' compensation, or other? ☐ Yes ☐ No If yes:
   A. Name of insurance company:_____
   B. Reason for benefits:_____

☑ Section III – RECORD OF PAY RECEIVED

List the gross amounts and dates of checks or cash, which were paid for the last eight weeks in the space below.

Pay Period Ending	Date Pay Received	GROSS Earnings	No. of Regular Hours Worked	Rate of Pay	No. of Overtime Hours	Rate of Pay for Overtime	Tips $$	Earned Income Credit (EIC)

If hours or rate of pay has varied in the above period, please state why.

☑ Section IV – EMPLOYER INFORMATION

What I have written on this form is true to the best of my knowledge. I know that if I give false information on purpose, I may be subject to prosecution for fraud.

Signature of Employer

Employer's Title

Name of Business

( ) (ext.)
Telephone Number

Address

Date Completed

Back to CF-ES 2620

Proof of Assets

Please select Proof of Assets Documents:

- Bank Statements for Checking, saving, money market accounts (all Pages) ☐
- Other Properties than Homestead (Include Property Tax Bills for each property) ☐
- Cash surrender value of life insurance if the combined face value of all policies owned by the family unit exceeds $1,500 ☐
- Additional automobiles or motor vehicles
  (With value determined by N.A.D.A. Book.) ☐
- Recreational vehicles
  (With value determined by a statement from a commercial seller of such vehicles and verified by photocopies of registration.) ☐
- Trusts
  (With value based on the principal of the trust and verified by a statement from the Trustee.) ☐
- Stocks, bonds and other investment assets statements ☐

COMPLETE ONE SECTION PER BANK ACOUNT

WVHA HEALTH CARD: Bank Account Checklist

➔ The House Next Door representative assisting in the application completion will utilize this checklist to verify all bank account documentation is submitted.

BANK ACCOUNT 1		
1. NAME ON ACCOUNT: (first) (last)		2. LAST 4 DIGITS OF ACCOUNT #:
3. ACCOUNT USED FOR: ☐ Business Only ☐ Personal Only ☐ Business & Personal		4. TYPE: ☐ Checking ☐ Savings
5. FIRST MONTH PROVIDED:	6. SECOND MONTH PROVIDED:	7. THIRD MONTH PROVIDED:
8. WERE ALL PAGES FOR EACH MONTH ENCLOSED?		☐ Yes ☐ No
9. VERIFICATION SUBMITTED FOR ALL ACTIVITY IN THIS ACCOUNT?		☐ Yes ☐ No

BANK ACCOUNT 2		
1. NAME ON ACCOUNT: (first) (last)		2. LAST 4 DIGITS OF ACCOUNT #:
3. ACCOUNT USED FOR: ☐ Business Only ☐ Personal Only ☐ Business & Personal		4. TYPE: ☐ Checking ☐ Savings
5. FIRST MONTH PROVIDED:	6. SECOND MONTH PROVIDED:	7. THIRD MONTH PROVIDED:
8. WERE ALL PAGES FOR EACH MONTH ENCLOSED?		☐ Yes ☐ No
9. VERIFICATION SUBMITTED FOR ALL ACTIVITY IN THIS ACCOUNT?		☐ Yes ☐ No

BANK ACCOUNT 3		
1. NAME ON ACCOUNT: (first) (last)		2. LAST 4 DIGITS OF ACCOUNT #:
3. ACCOUNT USED FOR: ☐ Business Only ☐ Personal Only ☐ Business & Personal		4. TYPE: ☐ Checking ☐ Savings
5. FIRST MONTH PROVIDED:	6. SECOND MONTH PROVIDED:	7. THIRD MONTH PROVIDED:
8. WERE ALL PAGES FOR EACH MONTH ENCLOSED?		☐ Yes ☐ No
9. VERIFICATION SUBMITTED FOR ALL ACTIVITY IN THIS ACCOUNT?		☐ Yes ☐ No

Form Completed by:

WVHA HealthCard Program: Bank Account Activity – Verification Sheet

Form Instructions: The WVHA HealthCard Applicant will utilize this form to verify various deposits in bank accounts (for example: cash deposits, deposits from your credit cards, or deposits from loans). Include all deposits over the past 3 months for each bank statement. Complete each section in full.

Line #	ACCOUNT # ENDING IN	DATE DEPOSIT/ TRANSFER	DOLLAR AMOUNT	DEPOSIT EXPLANATION	SUPPORTING PROOF ENCLOSED?	ONE TIME/ RECURRING?
#1 (ex)	1234	01/01/17	$98.00	Cash deposit from a week of babysitting	X Yes ☐ No	X One Time ☐ Recurring
#2			$		☐ Yes ☐ No	☐ One Time ☐ Recurring
#3			$		☐ Yes ☐ No	☐ One Time ☐ Recurring
#4			$		☐ Yes ☐ No	☐ One Time ☐ Recurring
#5			$		☐ Yes ☐ No	☐ One Time ☐ Recurring
#6			$		☐ Yes ☐ No	☐ One Time ☐ Recurring
#7			$		☐ Yes ☐ No	☐ One Time ☐ Recurring
#8			$		☐ Yes ☐ No	☐ One Time ☐ Recurring
#9			$		☐ Yes ☐ No	☐ One Time ☐ Recurring
#10			$		☐ Yes ☐ No	☐ One Time ☐ Recurring
#11			$		☐ Yes ☐ No	☐ One Time ☐ Recurring
#12			$		☐ Yes ☐ No	☐ One Time ☐ Recurring

APPLICANT SIGNATURE: Form is not valid unless signed – By signing this form you attest that the information written in this form is true and accurate to the best of your knowledge. The person signing this form understands that unverified deposits and/or omitting supporting documentation may result in delay of WVHA HealthCard enrollment.

APPLICANT NAME:	APPLICANT SIGNATURE:	Date Form Completed:
		/ /

Proof of ACA or FWA

YOU MUST PROVIDE ONE OF THE DOCUMENTS BELOW:

*Affordable Care Act Eligibility Determination Results (ACA) ☐
(ALL pages and DATE on results MUST be within 30 days of application Date)
3 Ways you can get your ACA Eligibility Determination Results:

1. Online: WWW.HEALTHCARE.GOV (Print ALL PAGES)

2. By Phone: Call (800)318-2596 (make sure you ask them to mail you a copy of your results)

3. In Person local help with a Certified Application Counselor (Call to make appointment) With Health Card Specialist at the House Next Door.

*Homeless: Medicaid Denial Letter OR ACA results ☐

*Farmworkers Association (FWA) Attestation Form **& Medicaid Denial** ☐
(For Non-Citizens & Dated within 30 days of application Date)
You can obtain your attestation form by going to:
Farmworkers Association
111 Fountain Drive
Pierson FL 32180
(386)749-9826