Community Health Care Network (CHCN) and Medical Care for Children Partnership (MCCP)

Date Received:

Current Address: _____ Check if applicable: ☐ shelter ☐ homeless ☐ public housing ☐ Other: _____

{Street Address & Apartment Number}

_____ Telephone: _____ _____ Best time to reach you: _____

{Town/City, State and Zip Code} ***Home*** ***Cell***

Date you moved to Fairfax County: _____ Do you speak English? Yes ☐ No ☐ If no, please list your language: _____

Please list *yourself* on the first line. List your spouse and all children **living at this address**. Continue on another sheet of paper if necessary.

Name	***Relationship***	***Date of Birth***	***Place of birth***	***Sex***	***Social Security Number***	***Citizenship/ Immigration***	***Pregnant***
	Self			☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No

Are any of the above household members on a temporary VISA? Yes ☐ No ☐ If yes, please list their name/s: _____

Is anyone listed above currently eligible or enrolled in a group, private or other health insurance program through a job, VA Benefits or an absent parent? Yes ☐ No ☐

If yes, please list the person's name and insurance program: Name/s: _____ Insurance: _____

Do any household members attend college? Yes ☐ No ☐ If yes, list members name: _____

Do other people live at this address? Yes ☐ No ☐ If yes, please list their name/s and check (✓) relationship below.

Name/s _____ ☐ Roommate ☐ Relative ☐ Landlord ☐ Other _____

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List any money received by any member of the household who is 18 or over. Include money from work, self-employment, day laborer, child support, disability, retirement, unemployment compensation, etc. (work includes but is not limited to babysitting, housekeeping, selling food, etc)

Who Receives Money?	**Gross Amount**	**Source (employer –company name, unemployment self-employment, child support, etc.)**	**How often (daily, weekly, two weeks twice a month, monthly)**
_____	$ _____	_____	_____
_____	$ _____	_____	_____

Do you or any member of your household receive General Relief? Yes ☐ No ☐ Have you or any household member currently applied for General Relief? Yes ☐ No ☐

Has any household member recently lost a source of income such as a job or financial benefits? Yes ☐ No ☐ If yes, list Name: _____ Date of loss: _____

Has anyone claimed you or one of your children as a dependent on their federal tax return? ☐ Yes ☐ No If yes, list their name: _____

Did you file a federal tax return for the previous year? Yes ☐ No ☐ Do you own more than one home? Yes ☐ No ☐

Does anyone in the family have assets such as: checking, savings, retirement accounts, stocks, certificates of deposit, money market, etc. Yes ☐ No ☐

If yes, list assets and value: _____

Expenses	**Amount**	**Shelter and Expense Contributions**
Rent ☐ Mortgage ☐ No Rent ☐ Other shelter expenses including electric, gas, water, trash, homeowner/condo association fees, etc: Total amount: $ _____	$ _____ $ _____	☐ I receive $ _____ each month from family or friends to pay my monthly expenses. ☐ I am totally supported by family members or friends and do not have any monthly expenses. Please list the name and relationship of the person(s) supporting you: Name/s:_____Phone:_____ Relationship: _____

I understand that to receive services from the Community Health Care Network and the Medical Care for Children Partnership, I must not be eligible for other health insurance programs, I must be a Fairfax county resident and household income must fall within current guidelines. I understand and agree to report any change in address, income, family size or health insurance coverage to the Enrollment Office within ***TEN {10}*** days of the change. I authorize the Department of Family Services to obtain any verification necessary to review and establish my eligibility for medical assistance including information from state and federal agencies. By signing below I certify that I have read the information above and agree to all conditions and terms. I also agree that all the information given on this application is true and correct to the best of my knowledge and belief.

I authorize (name) _____ and/or (organization) _____ at telephone _____ cell _____ to answer any questions about the information on this application and to receive information about my enrollment status.

Applicant Signature:_____ Date:_____

Please use this form to list additional members.

Name	*Relationship*	*Date of Birth*	*Place of birth*	*Sex*	*Social Security Number*	*Citizenship/ Immigration*	*Pregnant*
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
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