Health Access Assistance Team (HAAT) - 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 call ☐ AM ☐ PM ☐ Anything
{Town/City, State and Zip Code} *Home* *Cell*

Do you speak English? Yes ☐ No ☐ If no, please list your language: _____ ***email address:*** _____

Please list *yourself* on the first line. List your spouse/partner and all children **living at this address.** To list additional members, see the back of this page.

Name	*Relationship*	*Date of Birth*	*What school does this child attend?*	*Sex*	*Social Security Number*	*Citizenship/ Immigration*	*Pregnant*
	Self			☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ 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 above eligible or enrolled in a health insurance plan through Medicaid or an employer? Yes ☐ No ☐

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

Did you and/or your partner file a federal tax return for the previous year? Yes ☐ No ☐ If "Yes," list name/s: _____

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, GR, etc. (work includes but is not limited to babysitting, housekeeping, selling food, etc.)

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

I understand that to receive services from the Medical Care for Children Partnership, my children must not be eligible for any health insurance programs such as Medicaid. 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 children enrollment status.

Applicant Signature: ____ Date: __________________________

Please use this form to list additional members.

Name	*Relationship*	*Date of Birth*	*What school does this child attend?*	*Sex*	*Social Security Number*	*Citizenship/ Immigration*	*Pregnant*
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
			School name:	☐ M ☐ F		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No