ALPINE PEDIATRICS, P.C.
Family Assistance Plan Application

Name of Head of Household		Place of Employment		
Street	City	State	Zip	Phone
Health Insurance Plan		Social Security Number		

Please list spouse and dependents under age 18

Name		Date of Birth	Name		Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc				
Social Security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment, and dependents				
Rent, interest, dividend, and other income				
Total Income				

Verification Checklist (Attach copies)	Yes	No
ID: Driver's license, birth certificate, employment ID, social security card or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection (optional)		
Letter: Please give a brief explanation of your situation		

I certify that the information shown above is correct and understand verification is required for approval.

_____ _____

Name (Print) Signature/Date

Office Use Only

Pay class approved:_____ Effective date:_____

Approved by:_____ Expiration date:_____