

103 Bonnie Dr., Butler, PA 16002
 Phone: 724-841-0980 Fax: 724-841-0984 Website: www.butlerhealthclinic.org

Today's Date: _____

Interested in services? Visit the Community Health Clinic of Butler County to request "New Applicant Forms". Please remember to bring this completed form with you.

Person applying for Clinic Services: Last Name: _____ First Name: _____

Address: _____ City: _____ Zip: _____

Birthdate - (mm/dd/yyyy) Home Phone: _____ Cell Phone: _____

May we contact you at either phone number? Yes No May we leave a message? Yes No

Have you been served by this clinic before? Yes No

How can we help you at this time? Problem/Specific Symptoms: _____

Are you in need of any mental health medications? Yes No Are you currently receiving care from a mental health agency? Yes No Agency: _____

We first need to determine if you are eligible for our services by asking these questions:

Yes No Are you between the ages of 19 - 64?

Yes No Are you a Butler County resident?

Yes No Does your *household income meet the INCOME GUIDELINES listed below?
 *The CHCBC defines household as the # of dependents claimed on your most recent tax return

Yes No Do you have any health insurance?
 If yes, what type of insurance coverage? _____

Yes No Have you applied for Medical Assistance?
 If yes, how long ago? _____
 If yes, reason for denial? Excess Income, Excess Assets, Not Enough Working Hours, Incomplete documentation, Other: _____

INCOME GUIDELINES (200% of 2011 Federal Poverty Guidelines):			
Number in Household	Weekly Income	Monthly Income	Yearly Income
1	\$419	\$1,815	\$21,780
2	\$566	\$2,452	\$29,420
3	\$713	\$3,088	\$37,060
4	\$860	\$3,725	\$44,700
Add for each additional member:	\$147	\$637	\$7,640

CHCBC REPRESENTATIVE TO COMPLETE THIS SECTION

Circle if applicable - Client has been advised to apply for: Medical Assistance MAWD

Preliminary Eligibility Determination:

New Inquiries will be required to complete an Eligibility Appointment IF one of the following applies:
 (Please select one of the following options when scheduling an Eligibility Appointment)

Patient requests assistance in completing the eligibility process.

A CHCBC Representative has determined it necessary for individual to complete Eligibility Appointment

Patient's Scheduled Eligibility Appointment Date: _____ Time: _____

Volunteer Signature: _____ Date: _____

New Applicant Forms were picked up from CHCBC Date: _____

New Applicant Forms were returned to CHCBC Date: _____