Community Access Network

Free Clinic OF CENTRAL VIRGINIA

Community Health Center - 800 5th Street Martin Luther King Jr. Boulevard Lynchburg, Virginia 24504

Patient Attestation

(Patient Name:) _____ Social Security Number: _____Date: _____

I certify that the information I have provided is true and accurate according to the best of my knowledge. I agree to report any changes in insurance status or changes in income which bring me over my reported Federal Poverty Level within 7 days of the change. I understand that if I give false information or withhold information I will no longer be eligible for services from Community Access Network and the Free Clinic of Central Virginia. I understand that it is my responsibility to provide and update my eligibility every six months. I understand that the Free Clinic eligibility guidelines accepts patients up to 250% Federal Poverty Level, while Community Access Network has a reduced fee program that accepts patients up to 200% Federal Poverty Level.

☐ I do **NOT** have health insurance
☐ I **DO** have health insurance

Insurance Types:

☐ Medicaid
☐ Medicare A
☐ Medicare B
☐ Medicare D
☐ Veteran's Assistance
☐ Other/Private (Insurance Name): _____

☐ I do **NOT** have dental insurance
☐ I **DO** have dental insurance
Dental Ins. Name: _____

☐ I do **NOT** have Pharmacy insurance/coverage
☐ I **DO** have Pharmacy insurance/coverage
Pharmacy ins/cov Name: _____

☐ I do **NOT** file federal tax returns and I have (number) _____ of dependents that live in my household other than myself.

☐ I **Do** file federal tax returns and I claim (number) _____ of dependents on my taxes other than myself.

My household income is $ _____ (include social security, disability, alimony, pensions and annuities)

Cash Income Declaration

Please record your earnings for the last 2 months.

First Month (Month/Year) _____ / _____ Total = _____

Second Month (Month/Year) _____ / _____ Total = _____

Legal Representative Printed Name: _____

Patient/Legal Representative Signature: _____ Date: _____