COMMUNITY HEALTH FUND APPLICATION

Today's date:	

MEMBER INFORMATION

Member's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your first CHF request? ❑ Yes ❑ No	If no, what have you been funded for previously?	Enrollment Number:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Phone Number: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Category of Services Requested:				
❑ Vision	❑ Hearing Aid	❑ Orthotic & Diabetic Shoes	❑ Podiatry Foot Care	❑ Dental Care

ALTERNATE INSURANCE INFORMATION

(Please provide a copy of your insurance information)

Person who has alternate insurance:	Birth date: / /	Address (if different):	Phone Number: ( )

Occupation:	Employer:	Employer address:	Employer phone number: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance		

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

PROVIDER INFORMATION

Provider Name:	Address:	Phone Number: ( )	Fax Number: ( )

Please attach the Provider's referral or prescription to application and fax to the attention of Contract Health Staff at 360-966-7227.
If you have any questions please contact: **Jeff Bailey at 360-966-2106 or via email at jbailey@nooksack-nsn.gov**.

The above information is true to the best of my knowledge. I authorize Contract Health Staff to verify all information as stated. I understand that I am financially responsible for any balance. I also authorize Nooksack Health Clinic to release any information required to process my claims.

Signature	*Date*