Medical and Dental Services
ELIGIBILITY APPLICATION

FREE HEALTH CARE CENTER
CATHOLIC CHARITIES
DIOCESE OF PITTSBURGH

WWW.CCPGH.ORG

Date Received_____ Volunteer Initials_____

Discard Date_____

Completion Date_____ Volunteer Initials_____

This is not a walk-in clinic. Volunteer doctors and dentists are available by scheduled appointment only**.** To be reviewed for eligibility, you must complete, sign and submit this form plus any required documentation to Catholic Charities Free Health Care Center (CCFHCC). See other side for income guidelines and CCFHCC contact information. **Eligibility is re-evaluated annually. CCFHCC is not insurance.**

☐ DEMOGRAPHICS

Name _____ Social Security No. ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Address_____ City _____ State ____ Zip _____ County_____

Date/Year of Birth:_____ Sex: __F __M Marital Status: __Single __Married __Divorced __Separated

Telephone number/s where you can be reached during the day or where we can leave a message:

Home Telephone: _____ Other:_____ __cell __work __other

☐ EMPLOYMENT and INCOME

Are you employed? __NO __YES, I am employed: __Full Time __Part Time __Self-Employed

How often are you paid? __Weekly __Bi-weekly __Monthly __Other, explain:_____

Are you currently receiving income from any other sources? __NO __YES If YES, indicate which of the following you are receiving:

__Alimony __Pension Fund __Veterans Benefits __Workmen's Comp

__Child Support __Social Security Benefits __Unemployment Income __Other_____

☐ DEPENDENTS

Please list your spouse and dependents as shown on your tax documents. If more than four, attach sheet with additional information. We require proof of income for each family member listed on your tax return.

Name	*Age*	*Relationship*			
_____	_____	_____	__Employed	__Unemployed	__N/A
_____	_____	_____	__Employed	__Unemployed	__N/A
_____	_____	_____	__Employed	__Unemployed	__N/A
_____	_____	_____	__Employed	__Unemployed	__N/A

☐ STUDENT

Are you a college student? __YES __NO

If YES, are you listed as a dependent on your parent's income tax return? __YES __NO

Do you have health coverage under your parent's health plan? __YES __NO

Does your school include health benefits as part of your tuition? __YES __NO

☐ HEALTH INSURANCE/BENEFITS

Have you applied for Medical Assistance through the PA Department of Human Services?

__YES Date you last applied_____. Were you (check one): __ACCEPTED __DENIED

If denied, we REQUIRE a CURRENT copy of your Medical Assistance Denial Notice from the PA Department of Human Services.

__NO You are REQUIRED TO APPLY for Medical Assistance through the PA Department of Human Services and submit a copy of the Medical Assistance Notice indicating acceptance or denial.

Do you have medical coverage? Check all that apply.

__ YES: __Private __Medicaid /Medical Assistance __Medicare A & B __VA

__ NO

Dental Services If you are seeking dental services and have any of the following (check all that apply), and call the Eligibility Office at 412-456-6910 for further instructions.

__Private __Medicaid __Medicare A & B __VA __Medi-Gap __Medicare Advantage Plan
__Medicare Supplemental __Other:_____

I certify that the above information is true and accurate to the best of my knowledge.

Signature_____ Date_____

Required Documentation

1. **Completed and signed Eligibility Application.**

2. **Medical Assistance Denial Notice.**
   In order to receive a Medical Assistance Denial Notice, you must first complete the PA Department of Human Services Medical Assistance Application online, or go in person to the PA Department of Human Services, 332 Fifth Avenue, Pgh, Pa 15222.

   A Medical Assistance Denial Notice dated within 6 months is required.

3. **Federal Tax Information.**
   Tax Return Transcript for most recent tax filing year. (For the applicant or for the individual who claims the applicant as a dependent.)
   OR
   Verification of Non-Filing for the most recent tax filing year if applicant does not file a tax return.

   NOTE: The easiest way to acquire either of the two documents is to go in person to the Federal Building, 1000 Liberty Avenue, 15222, in downtown Pittsburgh. This is a free service and requires only that you show a valid ID card.

   If you are unable to go to the Federal Building, you can obtain a **Tax Return Transcript** or a **Verification of Non-Filing**, by downloading and completing a 4506-T Form. Enter the necessary information in items 1a, 1b, 3, 4, and 9; check 6a for Tax Return Transcript OR check 7 for Verification of Non-Filing. Sign and date the form and submit to the IRS. Please provide us with the form upon receipt from the IRS.

   As a final option, you can obtain a Tax Return Transcript by calling 1-800-908-9946 and responding to the automated prompts. Verifications of Non-Filing are not available through this telephone number.

   If you need additional assistance, call the Eligibility Office at 412-456-6910.

4. **Proof of ALL SOURCES of Income.**

   Please submit the appropriate document(s) from the following list for each individual residing in the home who is listed on your tax return as part of the household or as a dependent.
   - One month of recent consecutive pay stub/s
   - Social Security Benefits Statement
   - Unemployment Benefits Statement
   - Pension Statement
   - Child Support
   - Any other income source

Note: If you have no income source including family income or government benefits, please submit a Declaration of No Income provided by the CCFHCC.

Federal Poverty Guidelines

As of October 1, 2015, **household incomes not exceeding 250% of the poverty level**, based on Federal Poverty Guidelines, and who do not qualify for Medicaid or Medicare, may also be eligible for health services offered by Catholic Charities Free Health Care Center. CCFHCC is NOT insurance.

The 2016 chart to the right shows maximum household gross incomes (before taxes)—*annual and weekly*—that are no greater than 250% of Federal Poverty Guidelines.

2016 Federal Poverty Guidelines

Size of Family	100% Federal Poverty Guideline Annual Income	250% ANNUAL Income	250% WEEKLY Income
1	$11,880	$29,700	$ 571
2	$16,020	$40,050	$ 770
3	$20,160	$50,400	$ 969
4	$24,300	$60,750	$1,168
5	$28,440	$71,100	$1,367
6	$32,580	$81,450	$1,566
7	$36,730	$91,825	$1,766
8	$40,890	$102,225	$1,966

CCFHCC Eligibility Review Process

Submit this Eligibility Application to CCFHCC along with all supporting documentation by mail, fax, or in person. Upon receipt of all of your information, your file will be reviewed for eligibility, normally within two weeks.

MAIL *or* IN PERSON: Catholic Charities Free Health Care Center, Eligibility Office, 212 Ninth Street, Pittsburgh, PA 15222

FAX: 412-456-0128

NOTE: All information you submit is confidential and for use by the CCFHCC only and will not be shared with family, employer or other persons without your authorization except when CCFHCC is legally required to do so.

Questions? Call the CCFHCC Eligibility Office at 412-456-6910

Catholic Charities Free Health Care Center

As a vital part of Western Pennsylvania's health care safety net, and rooted in the Gospel and social teachings of the Catholic Church, we provide free, comprehensive care to uninsured and underinsured individuals, welcoming all with dignity, regardless of religion affiliation.