Free Clinic
OF CENTRAL VIRGINIA

1016 Main Street, Lynchburg, VA 24504

I, (Patient Name) _____ Social Security _____ 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 250% of 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 annually.

☐ 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 **NOT** have Pharmacy insurance / coverage

☐ I **DO** have Dental insurance ☐ I **DO** have Pharmacy insurance / coverage

Dental Ins. Name _____ Pharmacy Ins. 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 have (number) _____ of dependents that live in my household other than myself.

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 _____

Submit