

SAN LUIS OBISPO COUNTY MEDICAL SERVICES PROGRAM APPLICATION

EACH SECTION MUST BE COMPLETED

Full Name	Sex	Birthdate	Social Security Number	Marital Status
Applicant:				
Spouse:				
Residence Address:			City, Zip:	
Mailing Address if different than residence:			City, Zip:	

1. Place of Birth: _____ Ethnic Group: White Black Hispanic Asian Other : _____

2. Language: English Spanish Other :

3. Do you pay or receive child support or alimony under a court order? Yes No

4. Are you a student? Yes No

5. In the last 2 years have you:
 Sold or transferred real or personal property? Yes No
 Closed checking/savings accounts? Yes No
 Received a financial settlement or lump sum payments? Yes No

If YES, explain: _____

6. Have you had a personal injury/accident for which another party may be responsible for the medical expenses? Yes No
 Check those that apply: Medical Auto Homeowner's

7. Do you own motor vehicles, boats, trailers or motorcycles? Yes No
 How many? _____ Model / Class / Year: _____ Balance Owed \$ _____
 Model / Class / Year: _____ Balance Owed \$ _____
 Model / Class / Year: _____ Balance Owed \$ _____

8. Do you own Real Estate?
 House in which you are NOT living? Yes No Rental Property? Yes No
 Acreage / lots? Yes No Timeshare? Yes No
 Assessed value \$ _____ Balance owed \$ _____

9. Do you and/or spouse have:

Savings Account	Yes <input type="checkbox"/> No <input type="checkbox"/>	Veterans / GI Benefits	Yes <input type="checkbox"/> No <input type="checkbox"/>
Checking Account	Yes <input type="checkbox"/> No <input type="checkbox"/>	Social Security Income	Yes <input type="checkbox"/> No <input type="checkbox"/>
Certificates / IRA	Yes <input type="checkbox"/> No <input type="checkbox"/>	Child / Spousal Support	Yes <input type="checkbox"/> No <input type="checkbox"/>
Trust Funds	Yes <input type="checkbox"/> No <input type="checkbox"/>	Workers Compensation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stocks / Bonds	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cash Contributions	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pensions	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Income	Yes <input type="checkbox"/> No <input type="checkbox"/>
Unemployment / State Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>		

10. Applicant's Occupation:	Spouse's Occupation:
Currently employed? Yes <input type="checkbox"/> No <input type="checkbox"/>	Currently employed? Yes <input type="checkbox"/> No <input type="checkbox"/>
Employer:	Employer:
How often paid: weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly <input type="checkbox"/> twice monthly <input type="checkbox"/>	How often paid: weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly <input type="checkbox"/> twice monthly <input type="checkbox"/>
Gross income from paycheck \$	Gross income from paycheck \$
Date last paycheck received:	Date last paycheck received:
Date next paycheck expected:	Date next paycheck expected:

I hereby declare the answers given are correct and true to the best of my knowledge. I understand that I may be asked to prove my statements, and I hereby give permission to verify all information.

Signature of Applicant or Applicant's Representative

Date

COUNTY USE ONLY

Certification Period _____ SOC \$ _____

Eligibility Technician's Comments/Clarification
