



Free Medical Care

Atención Médica Gratuita

Requirements/ Requisitos:

- 1. Live in Broward/Vivir en Broward**
- 2. Low Income/ Bajos Ingresos**
- 3. Uninsured/ No tener seguro medico**

Contact: Patient Eligibility Coordinator, Maria Larrea

Phone: (954) 563-9876 ext. 206

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5333 N. Dixie Highway #201, Oakland Park, FL 33334

Email: enroll@lightoftheworldclinic.org

WHAT YOU WILL NEED:
(English)

Applicants must provide the following documents with their application for consideration and final approval.

1. COPIES of **2 forms of photo identification** for each person applying. ONE with your current address.
For children under 21: COPY of Birth Certificate and School ID for each minor child living at home.
2. **Proof of domicile requirements:**
Please supply ONE of the following documents.
 - a. COPY of **current lease agreement**/contract along with a copy of the last rent payment receipt. **OR**
 - b. COPY of **last paid mortgage statement**. **OR**
 - c. If you don't have a rental agreement or own a home - then you MUST submit a "Rent Verification Form" or an **ORIGINAL** notarized letter from Landlord with details of your current living arrangement:
 - Monthly rental amount
 - Complete address with city and zip code
 - Are utilities included?
 - Length or terms of living arrangement (monthly, yearly)
3. **Proof of Income requirements:** Please supply the document that best reflects your current situation and that of your spouse/partner.
Options:
 - a. **If you work for a company:** COPIES of paystubs for the last 6 consecutive weeks for ALL adults in the family.
 - b. **If your employer pays you in cash or you are self-employed:** you MUST submit an **ORIGINAL** notarized letter stating your occupation, indicate how you get paid and how much you earn (weekly or monthly).
 - c. **If you don't work,** you MUST still submit an **ORIGINAL** notarized letter stating that you have no income and explain why.
4. **CURRENT BILLS:** COPY of **two bills** from most recent month- FPL, phone, water, internet or other bill you have in your name.
5. **Most recent tax return:** COPY of ALL PAGES including W2/1099 if you filed one.

LO QUE NECESITARÁS:
(Spanish)

Aplicantes deben presentar los siguientes requisitos, los cuales serán revisados por la clínica para aprobación final.

1. COPIAS de **2 formas de identificación** de cada persona que aplica. UNA con foto y, de ser posible, con dirección actual para cada persona que está aplicando.
Para los hijos menores de 21 años: COPIA del Acta de Nacimiento e Identificación de la Escuela/Universidad para cada hijo que vive en el hogar.
2. **Prueba de vivienda o domicilio:**
Presentar UNA de las siguientes opciones:
 - a. **COPIA** del contrato de alquiler con copia del último recibo de pago de renta **Ó**
 - b. **COPIA** de la hipoteca y copia del último pago de hipoteca/"mortgage" **Ó**
 - c. Si no tiene contrato de alquiler o propiedad -puede entregar una carta **notariada (ORIGINAL)** por el dueño del hogar describiendo los detalles de la vivienda. La carta debe incluir:
 - Cuánto pagan mensualmente de renta
 - La dirección completa
 - Si incluye luz, agua, cable, internet
 - Fecha cuando se termina el contrato
3. **Prueba de ingreso:** Presente el documento que refleje su situación de ingresos y la de su pareja.
Opciones:
 - a. **Si trabaja en una empresa:** COPIA de los últimos desprendibles del cheque de pago de las últimas 6 semanas para todos los adultos en el hogar.
 - b. **Si le pagan en efectivo o trabaja por cuenta propia:** carta notariada (**ORIGINAL**) verificando empleo y detallando su tipo de trabajo e ingreso mensual.
 - c. **Si usted o su pareja no trabajan,** necesitan una carta notariada (**ORIGINAL**) donde declaran que no trabajan y que no tienen ingreso.
4. **FACTURAS MAS RECIENTES:** COPIAS de **dos facturas:** Luz, agua, Teléfono, cable u otra cuenta a su nombre.
5. **Declaración de impuestos:** COPIA de la declaración más reciente si han declarado con W2/1099(TODAS LAS PAGINAS).



VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM
CLINIC/PROGRAM/PROVIDER: Light of the World Clinic, Inc.

Section 1

Does the client/patient have insurance that covers the health or dental condition? YES _____ NO _____

Does anyone in the client/patient's family have an active FL Medicaid card? YES _____ NO _____

Name of the card holder and Medicaid No. _____

Client/Patient/Head of Household's Name: _____
 (LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: _____
 (STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: _____ Name of Contact: _____

Section 2

Family Size: Adults _____ Under 18 _____ 18-21--Student _____ Unborn _____ Family Size TOTAL _____

FAMILY MEMBERS NAME (First and Last)	DOB	EMPLOYER	GROSS EARNED INCOME LAST 4 WKS	GROSS UNEARNED INCOME LAST 4 WKS (Do not include TCA or SSI)
SELF			\$	\$
SPOUSE/PARTNER			\$	\$
CHILD			\$	\$
CHILD			\$	\$
CHILD			\$	\$
CHILD			\$	\$
		TOTALS	\$	\$
		Add earned and unearned income to determine total		TOTAL INCOME \$ _____

Section 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)

- Step 1.** "TOTAL FAMILY INCOME" for family unit (Earned and unearned income). (1) \$ _____ (Above)
- Step 2.** Subtract \$90 for EACH employed member of the family unit. (2) \$ _____ (Minus)
- (2a) \$ _____ (Total)
- Step 3.** Subtract childcare PAID each month (up to \$175 per child age 2 and older; up to \$200 per child under age 2). (3) \$ _____ (Minus)
- (3a) \$ _____ (Total)
- Step 4.** Subtract up to \$50 per month of total child support received. (4) \$ _____ (Minus)
- Step 5.** TOTAL NET INCOME (5) \$ _____ (Total)

Section 4 USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit. I acknowledge receipt of the Department of Health's Notice of Privacy Practices.

 SIGNATURE OF CLIENT/PATIENT/PARENT OR GUARDIAN AND DATE

 PRINT NAME OF DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE

(VALID FOR ONE YEAR) Expiration date: _____