GRANITE COUNTY MEDICAL CENTER
RURAL HEALTH DISCOUNT PROGRAM APPLICATION

Name of Head of Household:			**Place of Employment:**		
Mailing Address	**City**		**State**	**Zip**	**Phone**
Health Insurance Plan: Medicaid [ ] Medicare [ ] Blue Chip [ ] Private Insurance [ ] Montana Breast & Cervical [ ] Missoula Indian Health Center [ ]			**Social Security Number:**		

Please list spouse and dependents under age 18

	Name	Date of Birth		Name	Date of Birth
Self			**Dependent**		
Spouse			**Dependent**		
Dependent			**Dependent**		
Dependent			**Dependent**		

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veterans benefits				
Alimony, child support, military family allotments				
Income from business self employment and dependents				
Rent, interest, dividend, and other income				
TOTAL INCOME				

Verification Checklist	Yes	No
Identification/Address: Drivers License, Birth Certificate, Employment ID, Social Security Card or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Card(s)		
Medicaid: Application made or evidence of rejection		

I certify that the information shown above is correct and understand verification is required for approval.

______________________________ ______________________________

Name (Print) **Signature/Date**

______________________________ ______________________________

Name (Print) **Signature/Date**

Office Use Only

Pay Class Approved: ____________________ Effective Date: ________________

Approved by: __________________________ Expiration Date:_______________