



INDIGENT HEALTH CARE DIVISION

Eligibility Determination Checklist

Case #:

Client Name
Mailing Address
Mailing City, FL Zip Code

Appointment Details:
Date:
Location:

If you are unable to keep this appointment please call (863) 534-5387 prior to your appointment time. The information on this checklist is required by the Polk HealthCare Plan in order to determine your eligibility for reduced cost medical services. **Please bring all information listed below to your appointment interview. Please arrive on time and be prepared to talk about your situation.** The member services representative will have 30 days to determine your eligibility.

- I. You must provide two official documents to prove that you are a full time, permanent, **Polk County Resident** and that you have the intent to remain in Polk County.
- II. You must provide proof of all earned and unearned gross **HOUSEHOLD INCOME FROM ALL SOURCES for all household members for the past 3 months.** Acceptable items of income include: (A) Check stubs (B) Statements from employers including dates of employment (C) Award letters (D) Child Support (E) Current TANF (F) VA (G) Social Security award letter (H) Worker's Compensation Claim form (I) Unemployment Compensation, Wage transcript, or print out from the Unemployment Office (J) Previous years federal tax return or social security wage transcript (K) Verification of student loan(s) or PELL Grants(s) (L) If self-employed, most recent income tax filing and quarterly tax statement (M) Domestic Relations Department document(s) showing any child support or alimony received (N) If you are unemployed a statement(s) of support from any individuals providing assistance is required. This statement should include the dollar amount and frequency of the support.
- III. **Social Security Cards and Birth Certificate or Immigration Document** for all household members.
- IV. Polk County **Driver License** or State Picture Identification with your current address must be presented at the time of the interview for all adult household members.
- V. All vehicle registrations and vehicle insurance in your name.
- VI. You will also need proof of **All Household Assets**, including: 3 months of checking and/or savings account statements for all bank accounts where your name appears on the account. IRA's, Certificates of Deposit, Annuities, Trust Funds, Profit Shares, Commissions and Royalties, Stocks and Bonds. Assets also includes proof of all property owned, and/or any vehicles such as: cars, trucks, SUV's, motorcycles, water crafts, recreational vehicles, ATV's, etc.
- VII. **All Current Household Bills** such as rent or mortgage , all utilities, credit card bills, loan payments, rental fees, cell phone costs, auto insurance, auto payment(s), etc.
- VIII. Proof of application status for **SSD/SSI** from either an attorney or the Social Security Administration.
- IX. All State Assistance Award letters such as Food Stamps, Cash Assistance or Medically Needy Share of Cost.
- X. Other:

In order to be considered for eligibility you will be required to submit all documents that apply to your case. **Additional information may be requested during the interview based on your individual circumstances.** The Polk HealthCare Plan is for full-time, permanent, Polk County residents who meet eligibility requirements and have no other health insurance coverage available to them. If you are approved, The Polk HealthCare Plan has co-pays for prescription medications and medical services received. Co-pays are required to be paid at the time of service.

Member and Social Services
2135 Marshall Edwards Drive
Bartow, Florida 33830



PHONE: 863-534-5387
FAX: 863-534-7519
www.polk-county.net

**INDIGENT HEALTH CARE DIVISION
VERIFICATION OF SUPPORT**

This statement is to verify that I, _____,
provide financial support, as outlined below, to **Client Name** who is applying for the
Polk HealthCare Plan.

_____ Date

_____ Signature

_____ Name (Printed)

_____ Phone Number

_____ Address

_____ City

If the person applying for the Polk HealthCare Plan lives with you at the address above but you do not share any assets (such as a vehicle or bank account) and they do not pay rent to you, please attach to this form copies of all household bills for expenses they benefit from, such as rent/mortgage, phone, cable, electric, water, etc., and list the amounts in the spaces below. You do not need to include bills for expenses which do not benefit the person applying, such as *your* credit cards, *your* medical bills, *your* car payment, *your* auto insurance, etc.

Rent/mortgage \$ _____ Land line phone \$ _____

Cable \$ _____ Water \$ _____ Electric \$ _____

Other: _____ \$ _____

If you pay any of the applicant's bills, directly or by giving them the cash to pay them please include copies of those bills and list the amounts below. Examples of this might be if you pay the applicant's cell phone bill, or their auto insurance bill.

Bills paid for applicant: _____ \$ _____
_____ \$ _____

If you give cash to applicant for personal expenses (like toiletries or gas for their car), tell us approximately how much you give to them each month

\$ _____