Mosaic Health Center
Health Insurance and Income Verification Form

I, ____ (name)

currently residing at ____ (address)

attest that:

- I currently do not have **medical or vision insurance of any kind** (Medicaid, Medicare, private insurance, ACA insurance, or any other types of health insurance)

  OR

- I am **underinsured with limited benefits** such as coverage only for preventive and emergency care and no coverage for prescription medications. My insurance does not give me access to primary care services because the co-pay and/or deductible are unaffordable for me and/or because they do not cover the services I need.

Therefore I am eligible to receive care at Mosaic Health Center. I further understand that Mosaic Health Center provides services to individuals living at or below 300% Federal Poverty level (FPL).

Please provide the number of dependents in your household (include self/ spouse): ____________

Please provide the gross monthly income from all sources: ________________________________

I attest that the above information is accurate and true.

____

Signature

____

Printed Name

____

Date