

# LIFECENTER MEMBERSHIP ASSISTANCE APPLICATION



## STEP 1: Applicant information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_  cell  home  work

Email: \_\_\_\_\_

I am applying for:  New membership assistance  Renewal

## STEP 2: Household information

Please mark which line on the chart below represents your current household family size\* and income:

*\*Family size is determined by the total number of parents or caretakers and all children under the age of 21 who are tax-dependent, as well as any other tax-dependent residing in the household.*

Family Size	Household Annual Income	My Household size/income
1	≤ \$40,776	<input type="checkbox"/>
2	≤ \$54,936	<input type="checkbox"/>
3	≤ \$69,096	<input type="checkbox"/>
4	≤ \$83,256	<input type="checkbox"/>
5	≤ \$97,416	<input type="checkbox"/>
6	≤ \$111,576	<input type="checkbox"/>
7	≤ \$112,756	<input type="checkbox"/>

List persons\* living in household:

*\*Children under the age of 21 who are tax-dependent as well as any other tax dependent living in the household.*

First Name	Last Name	Age

### STEP 3: Consent & signature

#### THIS APPLICATION MUST BE RENEWED EVERY CALENDAR YEAR.

I certify that the above information is true and complete to the best of my knowledge, and that I do not have additional income not represented above. I agree, if necessary, to send additional information and documentation to support the above statements. I understand that membership assistance is based on need. In the event that I must cancel my participation, I will contact the LifeCenter immediately so assistance can be provided to others. I understand that if I falsify any of the above information, I will not be eligible for assistance now and/or in the future.

This partnership is a commitment of AtlantiCare and the member to each pay a portion of the monthly membership fee. If at the time of annual review; you are still in need of membership assistance, it is your responsibility to provide supporting documentation by the deadline; otherwise, your membership will expire and your membership will be terminated. All membership fees are non-refundable and non-transferable. Membership fees are subject to change when you reapply annually.

Employee Name: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### STEP 4: Schedule Your Appointment

Please contact the LifeCenter at **609-407-2260** or [lifecenter@atlanticare.org](mailto:lifecenter@atlanticare.org) to schedule your appointment. The appointment will take about 20 minutes.

*\*\* INCOME/HOUSEHOLD VERIFICATION REQUIRED AT TIME OF APPOINTMENT. PLEASE BRING YOUR APPLICATION AND A COPY OF YOUR MOST RECENT TAX RETURN (FRONT PAGE ONLY).*

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#### OFFICE USE ONLY:

- Documentation provided
- Approval date
- Membership agreement completed
- LC Rep/date:

