CHECK LIST FOR LSHA MEDICAL ASSISTANCE APPLICATION

Name ____

1. **PROOF OF RESIDENCY**

   You must be a resident of **Columbia County for 90 days.**

   Please provide a document dated (90) days old but not over (1) year old. Examples: old hospital bill, electric bill, pharmacy printout, etc. **All documentation presented for proof of residency must show name, same address as Financial Status Form.**

2. **IDENTIFICATION**

   - Florida Drivers License/FL Identification card

     (No out of state identification will be accepted)

     OR two of the following:

     (1) Birth Certificate
     (2) Voter's registration card
     (3) Alien registration card
     (4) Affidavit of Identification (notarized)

2. **INCOME: Please bring ALL that apply to you!!**

   - Most recent tax return, 1040 (including supporting schedules) and for all wage earners in household
   - Recent pay stubs
   - Bank statements
   - Unemployment/Workers Comp Statement
   - Child Support/Alimony
   - Social Security Benefits for any family member
   - Pensions/Retirement/Interest/
   - Veterans Benefits
   - Other appropriate supporting documents
   - Self Employment
     a. Bank statements for all business accounts
     b. Previous Year's Business Tax Return (complete w/attachments/schedules
     c. Current Business Financial Statements
   - Assets
     a. Checking and Savings accounts

PLEASE FILL OUT ENTIRE APPLICATION
DO NOT TURN IN AN APPLICATION WITH BLANK SPACES