



Kids Watch Pediatrics & Urgent Care

Low-Income Family Care Plan Application

(Primary Care Only Program)

Thank you for your interest in our affordable care program for children ages **0–21 years**. This plan is designed for **primary care services only**, including well visits and sick visits, at discounted rates. Please complete this form so we can determine eligibility.



Family Information

- Parent/Guardian Full Name: _____
- Date of Birth: _____
- Phone Number: _____
- Email Address: _____
- Home Address: _____



Child(ren) Information

(Please list all children who will be covered under this plan)

1. Full Name: _____ | DOB: _____ | Age: ____
2. Full Name: _____ | DOB: _____ | Age: ____
3. Full Name: _____ | DOB: _____ | Age: ____
4. Full Name: _____ | DOB: _____ | Age: ____

(Add more lines if needed)

\$ Household Information

- Number of people in household: _____
- Total monthly household income: \$_____

- Are you currently receiving (check all that apply):
 - SNAP/WIC benefits
 - Other state/federal assistance _____
 - None

Health Insurance Information

- Do your children currently have health insurance?
 - No, uninsured
 - Yes → Type of insurance: _____
- If you have Medicaid, please check:
 - Full Coverage (comprehensive benefits)
 - Limited Coverage (emergency/limited services only)
 - Pending Application
 - Denied Medicaid

Primary Care Provider (PCP) Status

- Do your children currently have a primary care provider?
 - Yes (Name: _____)
 - No

*(Reminder: This plan is designed for **Primary Care Only** at KidsWatch Pediatrics & Urgent Care.)*

Acknowledgment & Consent

I understand that the **KidsWatch Low-Income Family Care Plan** is a **primary care only program** and does not replace health insurance. Emergency care, specialist visits, second party labs, imaging, or hospital care are **not included**. I agree to pay the listed visit fees at the time of service. I certify that the information provided above is true and correct.

Parent/Guardian Signature: _____ Date: _____

 **For Office Use Only**

- Reviewed by: _____ Date: _____
- Tier Assigned: Tier 1 (\$75 Sick Visit) Tier 2 (\$100 Sick Visit) Tier 3 (\$150 Sick Visit)
- PCP Well Visit Eligibility: Approved (\$100)

Please call or visit our website for details on the in-house services we offer.