Christian Health Aid
...sharing makes a difference...

PO Box 336
Montezuma KS 67867

Phone: 620-846-2286 Fax: 888-879-0324
Email: info@cha.faith

Direct Primary Care Enrollment Form

CHA has a Program to share 50% of Direct Primary Care monthly charges in monthly payments for members on the **Traditional Program**. If you are on Direct Primary Care and would like CHA to share this cost with you, please complete and sign this form and return it to the above address along with a bill showing your monthly DPC expenses.

Today's Date _____

Name _____ CHA Membership Number: _____

Telephone _____ Email _____ Fax _____

Mailing Address _____

City, ST, Zip _____

Please provide information for all family members on your CHA membership who are on your DPC membership.

01 Name: _____ ☐ M ☐ F Birth Date: _____ DPC Monthly Cost: $_____
First name only

02 Name: _____ ☐ M ☐ F Birth Date: _____ DPC Monthly Cost: $_____
First name only

03 Name: _____ ☐ M ☐ F Birth Date: _____ DPC Monthly Cost: $_____
First name only

04 Name: _____ ☐ M ☐ F Birth Date: _____ DPC Monthly Cost: $_____
First name only

05 Name: _____ ☐ M ☐ F Birth Date: _____ DPC Monthly Cost: $_____
First name only

06 Name: _____ ☐ M ☐ F Birth Date: _____ DPC Monthly Cost: $_____
First name only

07 Name: _____ ☐ M ☐ F Birth Date: _____ DPC Monthly Cost: $_____
First name only

08 Name: _____ ☐ M ☐ F Birth Date: _____ DPC Monthly Cost: $_____
First name only

09 Name: _____ ☐ M ☐ F Birth Date: _____ DPC Monthly Cost: $_____
First name only

10 Name: _____ ☐ M ☐ F Birth Date: _____ DPC Monthly Cost: $_____
First name only

By signing below, I certify that this is an ongoing monthly expense, and I will inform CHA if I cancel my DPC membership. I understand that I must apply for sharing from the DPC Program each year. I have attached documentation showing my DPC charges per month.

Signature _____