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

PO Box 336
Montezuma KS 67867

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

Direct Primary Care Enrollment Form

The DPC program will share 50% of Direct Primary Care charges in monthly payments for all CHA members. 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.

Name: _____ Membership #: _____

Email: _____

Cell Phone: _____ Home Phone: _____

Mailing Address: _____

City, ST, & Zip: _____, _____ _____

Please provide the following information for all family members who are on your DPC membership:

Name: _____ DPC Monthly Cost: $_____
First name only

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First name only

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First name only

By signing below, I certify that this is an ongoing monthly expense for primary medical care, and I will inform CHA if my DPC membership changes or is cancelled. 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 of Responsible Party: _____ **Date:** _____