Name	DOB
Address	SS#
City, State	HRN
Zip Code	
Telephone	

Sliding Fee Eligibility Form

It is necessary for us to ask personal questions in order to give you a discount on our medical & behavioral health expenses. This information will be kept on file in our center in strict confidence. You must verify your income at least once a year. Your yearly income tax return with a copy of your W-2 form, payroll check stubs covering the past year, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income will be used to calculate the level of your payment.

Today's Date: _____ Number of people living in your home? _____

Marital Status: ☐ Married ☐ Widow(er) ☐ Single ☐ Divorced ☐ Separated

☐ Rent ☐ Own ☐ Live w/someone

Amount of Household Income?

You	Spouse	Children	Other	Total Family Income

Place of Employment?

You	Spouse	Children	Other

Do you receive any income from any of the following sources, and if so, how much?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Rental Income					
Interest Income					
Child Support					
Alimony					
Other (Specify)					

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes (List below) No

Give Names, DOB and SSN of all individuals living in the household.

Name	Date of Birth	Social Security Number

I declare the above information is true and have given the Gerald L. Ignace Indian Health Center, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Signature:	**Date:**	***Clinic Purpose Only*** **Income Code:**