

INCOME INFORMATION

Sources of Income	Name of Source	Gross Annual Income
Wages		
Self-employed (net receipts after deductions)**		
Social Security Benefits (SSI, Survivor's, Disability)		
Public Assistance (TANF, General Assistance, etc.)		
Child Support/Alimony		
Unemployment Benefits, Workers' Compensation		
Stocks, Dividends, Rental Property		
Interest Income		
Other (Pensions, Veteran's Benefits, etc.)		

****If you are self-employed, you must fill out a self-employment form. In addition, you must submit a copy of your most recent Federal Income Tax Return.**

YOU MUST INCLUDE PROOF OF INCOME SUCH AS PAYCHECK STUBS, COPIES OF UNEMPLOYMENT CHECKS AND/OR SOCIAL SECURITY CHECKS.

Without proof of income your application will not be processed and your enrollment into the program will be delayed. If you have difficulty getting proof of income, speak to the Health Center's Social Services Coordinator. If there are special issues you feel should be considered when we review your application, please include on a separate piece of paper.

ZERO INCOME

PLEASE FILL OUT ONLY IF YOU HAVE NO SOURCE OF INCOME

Name of last employer: _____ Date of last employment: _____

Please explain how your basic needs have been met:

Food: _____ Utilities: _____

Shelter: _____ Non-food items (clothing, etc.): _____

I, _____, certify that I have had no source of income since _____.

All Applicants: PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW.

- I agree to be responsible for my Health Center bills.
- I also agree to tell the Health Center if I become eligible for any other form of coverage.
- I understand that if I provide false or incomplete information, I may no longer qualify for a fee discount.
- I certify that the information I have given on this application is complete and true.

Signature _____ Date: _____

*Help is available for referral to financial assistance outside of the Health Center.
Please call our Director of Clinical Support and Allied Health Services at 625-8126.*