Application for Discounted Services

Proof of income is required prior to receiving discounted services.

First Name: _____ *Last Name:* _____ *Middle:* _ *Date of Birth:* _____/_____/_____

How many people live in your household?_____   Are you currently employed?   YES   NO

Do you split bills? (rent/utilities)   YES   NO   If employed, answer the below questions:

Do have proof of income with you today?   YES   NO   What is your hourly rate? _____

Do you have insurance?   YES   NO   How many hours worked in a week? _____

Name of employer? _____

List All Member of Household	Relationship to the Patient					Currently Employed		If Empoloyed		
Last Name, First Name	spouse	child	parent	friend	other	YES	NO	Hours worked per week	Hourly rate of pay	Employer Name
Mouse, Mickey	*X*					*X*		*40*	*$12.00*	*Disney Company*
									$	
									$	
									$	
									$	
									$	
									$	

Do you or does anyone in the household receive any of the following? If yes, please fill in the total amount received before taxes or deductions.

Alimony	YES	NO	$ _____	Pension	YES	NO	$ _____	
Cash Support from friends or family	YES	NO	$ _____	Social Security (SSI or SSD)	YES	NO	$ _____	
Child Support	YES	NO	$ _____	SRS Income (Cash Assistance/	YES	NO	$ _____	
Food Stamps	YES	NO	$ _____	Unemployment	YES	NO	$ _____	
Other	YES	NO	$ _____	Worker's Compensation	YES	NO	$ _____	

By signing below, I state that the above financial information is correct. I agree to provide all financial information on a yearly basis in order to qualify for discounted services. I agree to notify Atchison Community Health Clinic immediately if my financial situation changes during the year. I understand that if Atchison Community Health Clinic finds that I have intentionally given false information, I will immediately forfeit my rights to discounted services.

Signature: _____ Date: _____

Office Use Only: Initials: _____   Family Size: _____   Total Yearly Income: $_____   POI: YES   NO

Notes: _____

Medical: $10 $20 $30 $40   Full   Mental Health: $10 $20 $30 $40   Full   Dental: $10 $20 $30 $40   Full