

Application for Discounted Services

Proof of income is required prior to receiving discounted services. Include income for everyon in the household over the age of 18.

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 Employed		
	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	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: _____

SLIDE A - \$15.00 _____ SLIDE B - \$30.00 _____ SLIDE C - \$40.00 _____ SLIDE D - FULL FEE _____