Katy Trail Community Health recieves federal grant funding to assist in our provision of this sliding fee discount program. To comply with related grant regulations, it is necessary for us to obtain personal information from you regarding household income and size, which is used to determine eligibility for the program and what amount of discount may apply. The information you provide will be kept on file and in strict confidence. You are required to have you eligibility determined annually, or more frequently if your household income and/or family size changes.

PATIENT INFORMATION

Patient Full Name		
Address		
Phone Number	Date of Birth	Social Security #
Employer Name		If not employed, date of last day or work

HOUSEHOLD SIZE

Patient / Household Member Name	Date of Birth	Relation to Patient
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

HOUSEHOLD INCOME

(You must report all income for all household members. In addition we require proof of income including, most recent tax return, recent pay stubs, award letters, benefit statements,divorce decree and/or any other evidence of income sources and amounts)

Source of Income	Received by (check one) Self	Spouse	Child	Other	Amount	Frequency *(please circle)*	For Office Use Only
Earnings (wages, salaries, and self-employment income)					$	week month year	
Interest and/or dividend income					$	week month year	
Unemployment compensation					$	week month year	
Child Support					$	week month year	
Alimony					$	week month year	
Regular contributions from persons not living in the household					$	week month year	
Workers' compensation					$	week month year	
Social Security and/or Supplemental Security Income (SSI)					$	week month year	
Public assistance (includes TANF and other cash welfare)					$	week month year	
Rents, royalties, estate, and trust income					$	week month year	
Retirement/survivor/disability pensions and annuities (government & non-government)					$	week month year	
Veterans' payments					$	week month year	
Educational assistance (government & non-government)					$	week month year	
Non-government educational assistance					$	week month year	
Money income not elsewhere classified					$	week month year	
NOTE: If you disclose no houseold income, we request that you you explain your living situation on the following page and disclose the amount and source of any non-listed support you receive to enable you to afford housing, food and other basic essentials.						Annualized Income	

Explanation of Living Situation if No Income Reported:

By signing below, I consent to Katy Trail Community Health confirming any disclosed information on this application. I also understand and acknowledge that providing false information is considered fraud and will result in a denial of this application and that I will owe the charges for the services provided. I understand that my determination of eligibility is good until March 1st each year, at which time another application is required to continue participation in the sliding fee discount program. I agree to inform Katy Trail Community Health if my financial situation improves and will complete a new application at such for a redetermination of my eligibility and discount level.

Applicant Signature **Date**

OFFICE USE ONLY

INCOME VERIFICATION DOCUMENTS PROVIDED

Tax Form 1040, 1040A or 1040EZ ☐
Pay Stubs ☐
Other: _____ ☐
Other: _____ ☐
Other: _____ ☐
Other: _____ ☐
Other: _____ ☐

Household Size ☐
Income Level ☐
Sliding Fee Discount Level ☐

Application is: ☐ Accepted ☐ Rejected

If Rejected, please state reason:

_____

_____

_____

_____ _____

Completed By Date