

# Hyndman Area Health Center Sliding Fee Application Confidential Patient Income Information

Head of Household: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
*City*
*State*
*Zip*

Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Is Your Spouse Employed? \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

**List ALL household members and/or dependents (INCLUDING YOU), their ages and income:**

NAME	AGE	EMPLOYED		GROSS INCOME*	PER WEEK MONTH OR YEAR
		YES	NO		

**\* ATTACH COPIES OF LAST TWO PAY STUBS AND/OR PROOF OF ANY INCOME SUCH AS SOCIAL SECURITY, VETERANS BENEFITS, WORKERS' COMPENSATION, PUBLIC ASSISTANCE AND/OR UNEMPLOYMENT BENEFITS FOR ALL HOUSEHOLD MEMEBERS. IF YOU ARE SELF EMPLOYED SUBMIT YOUR MOST RECENT YEAR'S TAX RETURN.**

Are you or any member of your household self-employed?    YES \_\_\_\_\_    NO \_\_\_\_\_

If yes, please specify type of business and income after expenses AND attach a copy of last year's 1040 Tax Return :

Business: \_\_\_\_\_    Income: \_\_\_\_\_

**PLEASE LIST OTHER SOURCES OF INCOME:**

<b>SOURCE</b>	<b>YES</b>	<b>NO</b>	<b>AMOUNT</b>	<b>PER WEEK, MONTH OR YEAR</b>
Unemployment Compensation				
Social Security				
Disability Benefits				
Worker's Compensation				
Veterans Benefits				
Alimony				
Child Support				
Pension				
Interest				
Dividends				
Rental Income				
Estate/Trusts				
Other:				

**I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND ALL SOURCES OF INCOME REQUIRED HAVE BEEN REPORTED. I FURTHER UNDERSTAND THAT I NEED TO REPORT ANY INCOME CHANGES AS THEY OCCUR AND WILL BE REQUIRED TO UPDATE MY APPLICATION ONCE PER YEAR EVEN IF NO CHANGES OCCUR.**

Signed: \_\_\_\_\_