

CERTIFICATION OF INCOME

Name: _____ Date of Birth: _____ Date: _____

I understand that the health center will determine my eligibility based on these figures. I further understand that if I am found to have given inaccurate information, it will be grounds for the health center to disallow my discount and charge me for any discounts received based upon the false information.

Signature _____

MEMBERS OF HOUSEHOLD: (IF APPLYING FOR SLIDING SCALE)

Name	Date of Birth	M/F	Relation
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____
_____	____-____-____	_____	_____

Source of Income	Amount
_____	_____
_____	_____

Yearly Amount _____ # of people in household _____ Code _____

Staff Signature _____ Date _____ Exp. Date _____

Federal Register January 11, 2019

DISCOUNT SCHEDULE BASED ON 2019 HHS FEDERAL POVERTY INCOME LIMITS

Note: No patient will be denied services based upon the documented inability to pay

_____ By signing this line, I refuse to provide financial information and that I am aware that I am not eligible for any discounts