# Family Health Centers
## Reduced Fee Application Form

Family Health Centers believes that health care should be accessible to those who need it; further, as their means permit, individuals should participate in the cost of their care. Family Health Center's Reduced Fee Program is a household discount, based on household size and income.

| FOR OFFICE STAFF USE | |
|---|---|
| Offer Date | |
| Site | |
| Rep | |

☐ **Yes, I want to apply**

To apply; read, complete both pages of this application, provide proof of income and sign page 2. This is requested in order to determine the Reduced Fee amount. I understand that if Family Health Centers cannot make a determination due to an incomplete application, I might be charged the full fee for my medical, dental and/or pharmacy visits.

☐ **No, I do not want to apply**

I do not wish to participate in the Reduced Fee Program. I understand that any charges for which I am responsible will be billed to me and will not be reduced. I can apply for the Reduced Fee Program at any time in the future.

**Signature**: _____ **Date:** _____

Annual **household** gross income:

☐ $0-$11,000 ☐ $11,000-21,000 ☐ $21,000-$31,000 ☐ $31,000-$41,000 Other: $ _____

Full Name: _____ Birth Date: _____ Phone: _____

Best time to call: _____

Address: _____ City: _____ State: _____ Zip: _____

**Family Size**: Family size is defined as all household and/or family members who depend on the same income. **Please list your household members:**

| # | First Name | Last Name | Date of Birth | Does this person have an income | Please inform us if the following applies? | If seasonal, months this person receives income (example: Feb-Nov) |
|---|---|---|---|---|---|---|
| 1 | SELF (Same person listed above) please complete → | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |
| 2 | | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |
| 3 | | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |
| 4 | | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |
| 5 | | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |
| 6 | | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |
| 7 | | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |
| 8 | | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |
| 9 | | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |
| 10 | | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |
| 11 | | | | ☐ Yes ☐ No | ☐ PT ☐ FT ☐ Seasonal | |

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## Income Declaration

Please complete if applying for the Reduced Fee Program.

Name: _____ Birth Date: _____

I hereby certify that the income for my household (including all household/ family members) for the coming twelve months is as follows:

| | (Before Tax and Deduction) |
|---|---|
| Wages, salaries, commissions, tips | $ |
| Social Security Benefits | $ |
| Public Assistance (Food Stamps, TANF, etc.) | $ |
| Unemployment / Workers Compensations | $ |
| VA Benefits / Military Retirement | $ |
| Pensions and/or IRA Distributions / Railroad Retirement | $ |
| Rental, royalties, trusts, etcetera. | $ |
| Dividend and/or Interest Income | $ |
| Annuities | $ |
| Other income (specify source) | $ |
| **Total Annual Household Income** | **$** |

**ZERO INCOME HOUSEHOLDS ONLY - Please complete if you have NO source of income:**

**Please describe how your basic needs have been met:**

Food: _____ Shelter: _____ Utilities: _____

Other (clothing, soap, etc.): _____

I, _____ , certify that I have had no source of income since _____

Name of last employer: _____ Date of last employment: _____

***All Applicants:*** **PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW.**

I agree to be responsible for my Family Health Center bills. I also agree to inform Family Health Centers if I have an insurance and/or income change. I understand if I provide false or incomplete information I may no longer be considered for a discount and certify that the information I have given on this application is complete and true.

**Signature**: _____ **Date:** _____