SIERRA VISTA COMMUNITY HEALTH CENTER
SLIDING FEE SCALE APPLICATION

PROOF OF INCOME MUST ACCOMPANY COMPLETED APPLICATION

DATE OF APPLICATION: _____ **Telepone Number Home** _____

Work _____

NAME OF APPLICANT _____ _____ _____ **Cell** _____

Please Print *Fist* *M.* *Last*

RESIDENCE ADDRESS - ***No. & Street/Apt. No./Rural Route*** _____

MAILING ADDRESS - ***No. & Street/Apt. No./PO Box/Rural Route*** _____

CITY _____ **STATE** _____ **ZIP CODE** _____

STATUS ☐ **NEW** ☐ **RECERTIFICATION** ☐

HOUSEHOLD MEMBERS - Fill in all blanks **for everyone who lives with you whether you consider them household members or not.** You may use the back of the front page to list additional household members.

NAME [LAST, FIRST, MIDDLE]	Relation-ship to person applying	Date of Birth			Sex	Race	U.S. citizen		Legal Alien		In School		Social Security Number
		Mo	Day	Yr.			Yes	No	Yes	No	Yes	No	
1	Self												
2													
3													
4													
5													
6													
7													
8													

Have you ever used another name[s]? **YES** ☐ **NO** ☐ **If yes, list other name[s]** _____

Does anyone in your household have health insurance? **YES** ☐ **NO** ☐

How did you meet your medical expenses until now? _____

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INCOME

Do you or anyone living with you receive money from job training or work? **YES** ☐ **NO** ☐

Do you or anyone living with you get cash, gifts, loans or contributions from parents relatives, friends, or others? **YES** ☐ **NO** ☐

Do you or anyone living with you get any other money, cash, or checks? **YES** ☐ **NO** ☐

[Include school, grants, scholarships, loans, child support, unemployment, govt. checkes, property, investments, etc.]

LIST ALL OF YOUR HOUSEHOLD'S INCOME BELOW		INCLUDE ALL INCOME REGARDLESS OF SOURCE	
NAME OF PERSON WORKING OR RECEIVING MONEY	**NAME OF EMPLOYER, PERSON, OR AGENCY THAT PROVIDES THE MONEY**	**HOW OFTEN RECEIVED?**	**GROSS AMOUNT RECEIVED**

FRAUD PENALTIES: I understand that I will be subject to prosecution for fraud if I knowingly give false, incorrect or incomplete information in order to obtain, or try to obtain, or help someone else obtain, or try to obtain, medical assistance. I understand that I will be required to pay back any benefits received improperly for any person.

RESPONSIBILITY TO REPORT CHANGES - I understand that the information which I have provided during application, and information I will provide in the future is the basis for determining eligibility. I understand that I must report all changes in my situation to the Clinic staff within ten [10] days of change. eligibility. I understand that I must report all changes in my situation to the Clinic within ten [10] days of change.

DECLARATION - I have read all of the information in this application, or it has been read to me. I swear under penalty of perjury that the information I have given on this application and will give, is true, complete, and correct.

APPLICANT'S SIGNATURE _____ **DATE** _____

WITNESS SIGNATURE [if applicant signed with X] _____

SIGNATURE OF PERSON WHO HELPED COMPLETE APPLICATION _____

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F-953-01-033-5