INCOME DISCOUNT APPLICATION

This is Confidential Information

Your name (Last, First, Middle Initial)	Date of Birth: Month Day Year

A. **Income Sources:** Check other sources of income you are receiving:

☐ Employment _____ ☐ Self Employment ☐ Spouse employment _____

☐ Allowance ☐ Child Support ☐ Disability Insurance ☐ Worker's Compensation ☐ Social Security

☐ Alimony ☐ Unemployment Insurance ☐ Grants and scholarships providing for living quarters

☐ Other, please specify: _____

B. List yourself, spouse and minors who live with you that are supported by the family income	Relationship to you: D/S	Tobacco Use (Y/N)	Age	Source of Income	Social Security Number	Gross Monthly Income
	(self)					
					Total Gross Monthly Income	$

Note: If any household member uses tobacco, that individual needs to complete the 'Patient Tobacco Use Assessment Form'.

C. Financial Coverage for Health Care

1. Does yourself, spouse and minors in this family have coverage under any of the following:

Health Insurance	☐	Prepaid Health Plan	☐
Medicare	☐	Student Health Serv	☐
Military (Champus)	☐		

2.

	Medi-cal	CMSP?
2a. Full coverage:	☐	☐
2b. Emergency coverage	☐	☐
2c. Share of cost	☐	☐
2d. Not Eligible or Denied	☐	☐

3a. Briefly explain why sliding funds are needed for any applicant listed above: _____

_____

_____

I certify, under penalty of perjury, that the above information is true.

Medical Record No.

_____ _____

Signature of Applicant *Date*

*I certify that this Client is E**ligible** for the checked services below for the period_____ through_____.*

☐ ☐ Sliding Discount 'L' ☐ Not Eligible ☐ Other Comments: _____

_____ _____ _____

Signature of agency representative *Date* *Agency Name*

4. Changes during the Certification Period involving Income, Family Size or Financial Coverage for Health Care:

Date	Change	Client's Signature	Signature of Agency Representative