

Sliding Fee Application
Applicant Information

 Last Name First Name M.I. Phone Number

 Physical Address City State Zip Code

Do you have any Health Insurance? Yes or No Number of Family Members _____
 If yes, what? _____

List each person in household, include: Applicant, Spouse/partner, Children, and other individuals living in household

Last Name	First Name	M.I.	Date of Birth	Head of Household (Check one)	Income Source	Relationship	Medical Record #
						Self	

Breakdown the income by where it comes from:

Employment	\$	Disability	\$
Unemployment	\$	Pension Funds	\$
Self-Employment	\$	Savings/Trusts	\$
Social Security	\$	VA Benefits	\$
Child Support	\$	Spousal Support	\$
Housing Allowance	\$	Scholarships/Grants/Training Stipends	\$
Military Family Allotments	\$	Other Financial Support	\$
Support from a Family Member	\$		\$

	Amount (before taxes)	Times	Annualized
Weekly	\$	X 52	
Bi-Weekly	\$	X 26	
Semi-Monthly	\$	X 24	
Monthly	\$	X 12	
Annual	\$	X 1	

My signature below certifies under penalty of perjury that all declarations made in this eligibility statement for the receipt of federal funds are true, accurate, and complete.

 Applicant Signature Date