Application for Discounted Services

No patient will receive discounted services at Atchison Community Health Clinic without proof of total household income.

First Name: ____________ Last: ____________ Middle: ____ Date of Birth: ____________

How many people live in the home? ______ Do you split bills? (rent/utilities) ◯ Yes ◯ No

Do you have your proof of income with you today? ◯ Yes ◯ No Do you have insurance? ◯ Yes ◯ No

Are you currently employed? ◯ Yes ◯ No *If yes, please answer the following questions.*

Hours worked a week? _____ What is your hourly rate? _______ Name of Employer? ____________

Please list all other members in your household besides yourself.

Name: ____________

Relationship: ◯ Spouse ◯ Significant Other ◯ Child ◯ Parent ◯ Friend ◯ Other: ____________

Currently Employed: ◯ Yes ◯ No

If yes, please answer the following questions.

Hours worked per week? _______ Hourly rate? ________

Name of Employer: ____________

Name: ____________

Relationship: ◯ Spouse ◯ Significant Other ◯ Child ◯ Parent ◯ Friend ◯ Other: ____________

Currently Employed: ◯ Yes ◯ No

If yes, please answer the following questions.

Hours worked per week? _______ Hourly rate? ________

Name of Employer: ____________

Name: ____________

Relationship: ◯ Spouse ◯ Significant Other ◯ Child ◯ Parent ◯ Friend ◯ Other: ____________

Currently Employed: ◯ Yes ◯ No

If yes, please answer the following questions.

Hours worked per week? _______ Hourly rate? ________

Name of Employer: ____________

Name: ____________

Relationship: ◯ Spouse ◯ Significant Other ◯ Child ◯ Parent ◯ Friend ◯ Other: ____________

Currently Employed: ◯ Yes ◯ No

If yes, please answer the following questions.

Hours worked per week? _______ Hourly rate? ________

Name of Employer: ____________

Name: ____________

Relationship: ◯ Spouse ◯ Significant Other ◯ Child ◯ Parent ◯ Friend ◯ Other: ____________

Currently Employed: ◯ Yes ◯ No

If yes, please answer the following questions.

Hours worked per week? _______ Hourly rate? ________

Name of Employer: ____________

Name: ____________

Relationship: ◯ Spouse ◯ Significant Other ◯ Child ◯ Parent ◯ Friend ◯ Other: ____________

Currently Employed: ◯ Yes ◯ No

If yes, please answer the following questions.

Hours worked per week? _______ Hourly rate? ________

Name of Employer: ____________

Do you or anyone in your home receive any of the following? If yes, please fill in the total amount received before taxes or deductions.

Unemployment?.....................................: ◯ Yes ◯ No $________
Worker's Compensation?.........................: ◯ Yes ◯ No $________
Food Stamps?..: ◯ Yes ◯ No $________
Alimony?..: ◯ Yes ◯ No $________
Child Support?...: ◯ Yes ◯ No $________
Pension?...: ◯ Yes ◯ No $________
Social Security (SSI or SSD)?...................: ◯ Yes ◯ No $________
SRS Income (Cash Assistance/Temporary Aid)?.....: ◯ Yes ◯ No $________
Cash support from friends, family or shelters?....: ◯ Yes ◯ No $________
Other: ____________________?.......: ◯ Yes ◯ No $________

For office use only:
Family Size: ______ Total Yearly Income: $__________
Proof of Income: ◯ Yes ◯ No

Notes: ____________

Medical:	$10	$20	$30	$40	Full Fee
Mental Health:	$10	$20	$30	$40	Full Fee
Dental:	$10	$30	$40	$40	Full Fee

Initials:

By signing below, I state that the above information is correct and I have provided it to receive discounted care. I agree to provide all financial information on a yearly basis in order to qualify for discounted services. I agree to notify Atchison Community Health Clinic immediately if my financial situation changes during the year. I understand that if Atchison Community Health Clinic finds that I have intentionally given false financial information, I will immediately forfeit my right to discounted services.

Signature: ______________________ **Date:** __________

Revised: 06/30/2016