INNIS, LIVONIA, & MARINGOUIN COMMUNITY HEALTH CENTERS
CARING FOR THE HEALTH NEEDS OF THE COMMUNITY

STATEMENT OF INCOME

Innis __ Livonia __ Maringouin ___

Directions: Please complete the following Household Financial information. All information must be completed in order to qualify to pay for services using a sliding scale fee schedule. This information will be kept on file in strict confidence. You must verify your income at least every six months. Your annual income will be used to calculate the level of your payment.

Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone : _____
Date of Birth: _____ SS #: _____

1.Total Gross Annual Income : _____ (Bring check stub or W2 or most recent tax form)

2. Place of Employment : _____

3. Please place a check mark by the following which may apply to you, your spouse, or your children and give specific amounts:

Income Source	You	Your Spouse	Your Children	Total Source of Income	Income Source	You	Your Spouse	Your Children	Total source of Income
Social Security					Food Stamps				
Unemployment					Dividends or royalties				
Workman Comp					Retirement pension				
Public Assistance					Interest income				
Veterans Benefits					income from estates /trusts				
Child Support/Alimony					Rental income				
Military Family Allotments					Regular support from someone not living with You				
Social Security-Spouse, children or others.					Other, please specify				

INCOME DETAIL FOR DEPENDENTS

Dependent's Name	Date of Birth	Income Amount	Frequency of payments monthly/yearly	Proof: examples check stub, food stamps, child support letter

Do you have any type of insurance that will cover a portion of your medical expense? Yes_____ No _____

I certify that I have read or had read to me the above questionnaire and that all of the information supplied is correct. I understand that failure to make full disclosure of my true gross income is considered an act of fraud and can be punishable by either/or a fine or imprisonment according to federal law. I have given Innis Community Health Center permission to investigate the information given in this application. I also understand if my income should change that I am required to notify the receptionist on my next clinic visit.

Signature _____ Date: _____