Katy Trail Community Health recieves federal grant funding to assist in our provision of this sliding fee discount program. To comply with related grant regulations, it is necessary for us to obtain personal information from you regarding household income and size, which is used to determine eligibility for the program and what amount of discount may apply. The information you provide will be kept on file and in strict confidence. You are required to have you eligibility determined annually, or more frequently if your household income and/or family size changes.

PATIENT INFORMATION

Patient Full Name		
Address		
Phone Number	Date of Birth	Social Security #
Employer Name		If not employed, date of last day or work

HOUSEHOLD SIZE (Please list all members of your household whom you are financially responsible for, **including yourself**)

Patient/Household Member Name	Has Income (y/n)	Date of Birth	Relation to Patient	KTCH Patient (y/n)
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

HOUSEHOLD INCOME *(You must report all income for all household members. In addition, we require proof of all income. Most recent tax return is the preferred method or recent pay stubs, award letters, benefit statements,divorce decree and/or any other evidence of income sources and amounts)*

Source of Income	Received by (check one)				Amount	Frequency (Check one)			For Office Use Only
	Self	Spouse	Child	Other		*week*	*month*	*year*	
Earnings (wages, salaries, and self-employment income)					$				
Interest and/or dividend income					$				
Unemployment compensation					$				
Child Support					$				
Alimony					$				
Regular contributions from persons not living in the household					$				
Workers' compensation					$				
Social Security and/or Supplemental Security Income (SSI)					$				
Public assistance (includes TANF and other cash welfare)					$				
Rents, royalties, estate, and trust income					$				
Retirement/survivor/disability pensions and annuities (government & non-government)					$				
Veterans' payments					$				
Educational assistance (government & non-government)					$				
Non-government educational assistance					$				
Money income not elsewhere classified					$				
NOTE: If you disclose no houseold income, we request that you you explain your living situation on the following page and disclose the amount and source of any non-listed support you receive to enable you to afford housing, food and other basic essentials.						Annualized Income			

Explanation of Living Situation if No Income Reported:

By participating in the KTCH Sliding Fee Discount Program I am aware that KTCH will provide phone calls and text messages for reminders and information regarding my sliding fee discount.

☐ Yes I would like to receive texts/calls ☐ No, I would not like to receive texts/calls

By signing below, I consent to Katy Trail Community Health confirming any disclosed information on this application. I also understand and acknowledge that providing false information is considered fraud and will result in a denial of this application and that I will owe the charges for the services provided. I understand that my determination of eligibility is good for exactly one year from date of application, at which time another application is required to continue participation in the sliding fee discount program. I agree to inform Katy Trail Community Health if my financial situation improves and will complete a new application at such for a redetermination of my eligibility and discount level.

Applicant Signature **Date**

OFFICE USE ONLY

INCOME VERIFICATION DOCUMENTS PROVIDED

Tax Form 1040, 1040A or 1040EZ ☐

Pay Stubs ☐

Other: ________________ ☐

Other: ________________ ☐

Other: ________________ ☐

Other: ________________ ☐

Other: ________________ ☐

Eligibility Period

Start Date ________________

End Date ________________

Household Size ☐

Income Level ☐

Sliding Fee Discount Level ☐

Application is: ☐ Accepted ☐ Rejected

If Rejected, please state reason:

____

____

____

Completed By Date