CLINICA SLIDING FEE DISCOUNT PROGRAM APPLICATION

Section I: APPLICANT Homeless:

Today's Date:

Last Name	**First Name**	**Middle Initial**	**Phone Number**

Address	**City**	**Zip Code**	**County**

	List Household Members	**Dependent Code**	**Program Qualification Code**	**Date of Birth**	**Social Security Number or Health First CO/CHP+ Number**
1.	APPLICANT				
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Comments:

Dependent Code 1. Self 2. Spouse/Civil Union Partner 3. Minor 4. Senior 5. Adult Student 6.Other

Program Qualification Codes

1. Counted in Family Size Only
2. Clinica Sliding Fee Only

Section II: Calculating Income

Income Source	Monthly Income	Annualized Total
1. Gross Employment Income	$	$
2. Unearned Income	$	$
3. Self-Employment Income	$	$
4. **Total Income (Lines 1 + 2 + 3)**	$	$

5. Allowable Deductions (See Worksheet 2) $

6. **Grand Total** Income (Lines 4-5) $

FPL Percentage:

CLINICA FAMILY HEALTH PROGRAM

Worksheet 1 - Earned, Self-Employment and Unearned Income

Payment Sources	Monthly Income	Annualized Income	Documented	Self-Declared
Earned Income:				
Employment Income	$	$		
Self-Employment Income:				
Net Self-Employment Income	$	$		
Unearned Income:				
Unemployment/Workers Compensation	$	$	☐	☐
Old Age Pension (OAP)	$	$	☐	☐
Supplemental Security Income (SSI/SSDI)	$	$	☐	☐
Retirement Plans/Pensions:				
	$	$$	☐	☐
		$$	☐	☐
		$		
Commissions, Bonuses, Gifts, Tips	$	$	☐	☐
Alimony Received	$	$	☐	☐
Rental Property Income	$	$	☐	☐
Interest Income from interest bearing accounts	$	$	☐	☐
Monetary/Capital Gains	$	$	☐	☐
Monetary Settlements (do not annualize, show total amount received)	$	$	☐	☐
Income from other Sources:				
	$	$$	☐	☐
		$$	☐	☐
		$$	☐	☐
		$		
Total Income	**$**	**$**		

CLINICA FAMILY HEALTH
Worksheet 2 - Allowable Deductions

	Monthly Expenses	Annualized Expenses
Elderly Care	$	$
Day Care	$	$
Paid Alimony	$	$
Child Support	$	$
Health Insurance Premium(s)	$	$
Pharmaceuticals	$	$
Use of Personal Vehicle for Business (if yes, put $200 for monthly)	$	$
Subtotal	$	$

Outstanding Medical Bills from a Hospital Provider incurred regardless of age. . ***(PAYMENT PLANS MUST BE DOCUMENTED)***

Health Provider	Date Incurred	Outstanding $ Amount	Total Monthly $ Amount Paid	Annualized $ Amount
		$	$	$
			$	$
			$	$
			$	$
			$	$
			Subtotal:	$

Total Monthly $

Fully paid and Single Payment Medical Expenses incurred during the past 12 months, applied as a single flat deduction to income. ***MUST BE DOCUMENTED*** (attach receipts)

Medical Expense Description	Date Paid	Amount Paid	Annualized $ Amount
		$	$
			$
			$
			$
			$
			$
		Subtotal:	$
		Grand Total:	$

(use this figure on Line 5 of Section II of the application)