Adult and Child Health Center

Financial Reassessment

TO BE COMPLETED EVERY JANUARY

Please fill out the application completely and attach all income information or submit within 30 days.
Adjustments will go back 30 days from the date the application is approved.

CLIENT INFORMATION

Last Name: ____________________ First Name: ____________________ Client ID: ____________________

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Home Address: ____

____ Phone Number: (Home) (   ) ____-____

City/State ____________________ Zip ____________ Phone Number: (Cell) (   ) ____-____

HOUSEHOLD INFORMATION

List all household members:

Name	Social Security No.	Date of Birth	Relationship
	- -	/ /	
	- -	/ /	
	- -	/ /	
	- -	/ /	
	- -	/ /	

PROOF OF INCOME

You must bring proof of income within 14 days:

( ) Most Recent Income Tax Return
( ) Social Security/Disability
( ) Form 4506-T
( ) 2 Pay Stubs

Annual Gross Income $ ____________________
(rounded to nearst $1,000 before tax)

Number of Dependents ____________________
(# of household members dependent on income)

I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge.

____ ____________________
Applicants Signature Date

(   ) DOES NOT WANT TO APPLY FOR SLIDING FEE ELIGIBILITY

I understand that by signing below, I am choosing to not provide my income information and therefore will not be considered for sliding fee eligibility.

____ ____________________
Applicants Signature Date

ELIGIBILITY INFORMATION - FOR OFFICE USE ONLY

☐ Application Approved ( ) 0% Payment (A) ( ) 20% Payment (B) ( ) 40% Payment (C)
( ) 60% Payment (D) ( ) 80% Payment (E)

☐ Application Denied - RESPONSIBLE FOR 100% OF BILL ( ) 100% Payment (F)

____ ____________________
Processed By Date

Client Name: ______________________________ Client ID: ____________________