EAST VALLEY COMMUNITY HEALTH CENTER, INC.
CERTIFICATION FOR FAMILY INCOME

Patient
Discount: _____
Under Section: _____

This is confidential information

A.

_____ _____
Patient Name (Last, First, Middle Initial) Date of Birth (Month, Day, Year)

B. 1. Are you currently employed? ☐ Yes ☐ No 2. Are you self-employed? ☐ Yes ☐ No
3. If NO, when did you last work? _____
4. What is your place of employment? _____ Type of work_____
5. How many hours do you work each week? _____ Hours Amount of last paycheck: $_____
6. When are you paid? ☐ Once per week ☐ Every two weeks ☐ Twice per month ☐ Once per month

7. Check other sources of income you are receiving:
☐ Allowance ☐ Child Support ☐ Disability Insurance ☐ Workman's Compensation ☐ Social Security ☐ Alimony
☐ Unemployment Insurance ☐ Grants & Scholarships Providing for Living Expenses ☐ Tips ☐ Other, Specify _____
How much?: _____ How often?: _____

8. List other persons who live with you and contribute to the Family Income	Relationship	Age	Sources of Income	Monthly Income (Take Home Pay)

9. List family members who are your dependents				

10. Total Number of Persons Depending on Income: _____ 11. . Total Household Income: $_____

12. Documents Needed: ☐ Proof of Income ☐ Address Verification ☐ I.D.

C. Financial Coverage For Health Care
1. Check if client has coverage for any of the following:
☐ Student Health Services ☐ Health Insurance ☐ Prepaid Health Plan
☐ Medi-Cal ☐ Military (CHAMPUS) ☐ General Relief

2. Is client claimed as a dependent or married, and do parents or spouse have health care coverage? ☐ Yes ☐ No
If YES, please specify coverage: _____

I certify, under penalty of perjury, that the above information is true.

_____ _____ _____
Signature of Applicant Date Medical Record Number

I certify that this client is Eligible for services on Sliding Scale Fee Section _____ for the period of six month through _____

_____ _____
Signature of Agency Representative/Title Date

Changes during the Certification Period involving Income, Family Size or Financial Coverage for Health Care.

Date	Changes	Client Signature	Signature of Agency Representative

ANY CLIENT REFUSED ELIGIBILITY HAS THE APPEAL RIGHT.