FIRST care CLINIC

HOUSEHOLD ASSESSMENT INFORMATION

Patient Name: _____ Date of Birth: _____

I understand that by filling out the information below, I will be eligible to participate in the Sliding Fee Scale Program subject to income guidelines. I agree to pay the full and entire amount for treatment given to me or to the above-named patient as determined by the Sliding Fee Scale Program. I also understand that I will be considered a "full fee" patient after the first visit and for every visit thereafter until proof of income is provided.

Patient/Guardian Signature: _____ Date: _____

HOUSEHOLD INFORMTATION

Please list all members of your household, including yourself

Name	Relationship	Date of Birth	Age	Sex	Annual Income

FOR OFFICE USE ONLY

IDENTIFICATION / ADDRESS:
Driver's License, Employment ID, Birth Certificate, Social Security Card, Utility Bill, Cable Bill — YES ☐ NO ☐

INCOME
Prior Year Tax Return, 2 Most Recent Pay Stubs, Unemployment Statement, Disability Statement, Documentation of Government Assistance, Child Support/Alimony, Statement of Assistance — YES ☐ NO ☐

Verified By: _____ Slide: A B C Full Fee