Frontera Healthcare Network

CERTIFICATION OF INCOME

Name: ______________________________ Date of Birth: _________________________ Date: _______________________________

I understand that the health center will determine my eligibility based on these figures. I further understand that id I am found to have given inaccurate information, it will be grounds for the health center to disallow my discount and charge me for any discounts received based upon the false information.

Signature ____

MEMBERS OF HOUSEHOLD: (IF APPLYING FOR SLIDING SCALE)

Name	Date of Birth	M/F	Relation
___________________________	______-_______-________	_______	_____________
___________________________	______-_______-________	_______	_____________
___________________________	______-_______-________	_______	_____________
___________________________	______-_______-________	_______	_____________
___________________________	______-_______-________	_______	_____________
___________________________	______-_______-________	_______	_____________

Source of Income	Amount
_____________________________________	____
_____________________________________	____

Yearly Amount ____ # of people in household __________________ Code________________

Staff Signature ____ Date ________________________ Exp. Date________________________

Federal Register

DISCOUNT SCHEDULE BASED ON HHS FEDERAL POVERTY INCOME LIMITS

Note: No patient will be denied services based upon the documented inability to pay

____By signing this line, I refuse to provide financial information and that I am aware that I am not eligible for any discounts