Camai Community Health Center, Inc.
Discount Application

ALL INFORMATION IS CONFIDENTIAL

Why do we need to know your household income?

- Some of our funding comes from grant monies that require income information from our patients to prove a financial need in the communities we serve.
- These grants allow us to provide a much higher level of care than we could otherwise afford.

Definitions:

Household members:

All members of a household who are related and/or pooling financial resources are counted as one family.

Income:

Income is defined as monies received from all sources before taxes, including:

- Wages and Salaries
- Receipts from self-employment less operating expenses
- Payments from public assistance, social security, strike benefits, military allotments, disability, child support, government or private pensions, regular insurance or annuity payments
- Income from dividends (including permanent fund & longevity dividends), interest, rents, royalties, estates or trusts

Eligibility Determination

Household members/ Household income:

List your name and the name(s) of **ALL** individuals who live with you.

Name:	Relationship:	Annual Income
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TOTAL # IN HOUSEHOLD: _____ **TOTAL HOUSEHOLD INCOME: _____**

***This information must be updated each year, and anytime your income, household size and/or medical insurance status changes. This is a self declaration of income. Camai Community Health Center, Inc., may request additional income information such as last year's w-2, tax return or a pay stub.**

****I understand that the information I provided on this form is subject to verification by Camai Community Health Center, Inc. and/or federal agencies. I authorize the community health center to disclose this information to agencies, third party payers and other health care providers as necessary to qualify me for reduced fees. I certify that the above information is true and correct to the best of my knowledge.**

☐ **I CHOOSE NOT TO PROVIDE THE ABOVE INFORMATION WITH THE COMPLETE UNDERSTANDING THAT I AM RESPONSIBLE FOR FULL CHARGES**

_____ _____
Patient/Guardian Signature Date Printed Name

_____ _____
Signature of Health Center Representative Date Discount % to be applied

Patient Chart # _____