1	Part 1 TO BE COMPLETED BY THE PATIENT							
2	**FAMILY MEMBERS**			Income - enter the **GROSS** (before taxes) amount You and your Spouse/Partner earns in the proper column (based on pay frequency) below:				
3	**RELATIONSHIP**	**NAME (first and last)**		**If Paid Hourly**	**If Paid Weekly**	**If Paid Every 2 Weeks**	**If Paid Twice a Month**	**If Paid Once a Month**
4	You (Patient):			$	$	$	$	$
5	Spouse/Partner:			$	$	$	$	$
6	Names of Children under 18 years of age (first and last):							
7	Child's Name:							
8	Child's Name:							
9	Child's Name:							
10	Child's Name:							
11	Child's Name:							
12	Child's Name:							
13	Child's Name:							
14	Number of family members (add lines 4 through 13)	Total No. =						

15 16	Part 2 TO BE COMPLETED BY MBCHC STAFF							
17	**Medical - all services except Dental**							
18	Slide - Circle One	A B C D E	Nominal Fee - Circle One	$10	$25	$50	$75	$101
19	**Dental**							
20	Slide - Circle One	A B C D E	Nominal Fee - Circle One	$10/10%	$25/25%	$50/50%	$75/75%	Full Fee

21 **Proof of income provided :** __Tax return ___ Pay Stub ____Letter from Employer ___Letter from Public Assistance Agency ___Self Declaration

22 **____ I have reviewed the above enrollment information, proof of income and the calculation of qualifying income and have approved the patient(s) for participation in the Sliding Fee Discount Program.**

23 Signed by: ______________________ Date ______________

24 Printed name of signer: ______________________

25 **Application expires March 31; new application required each April 1.** Rev 8/2018