

**Catholic Health Home Response
Sliding Fee Scale APPLICATION**

Please provide all of the following information and attach the appropriate supporting documentation.
*** Please be advised that this application cannot be processed without all of the required documentation.
Applicant must also sign and date this application.***

Subscriber Name _____
(First) (Middle) (Last)

Guarantor Name _____
(First) (Middle) (Last)

Address _____
(No. and Street) (City) (State) (Zip)

Phone _____ Date of Birth _____

Family Size _____ (spouse or children living with you)

Name _____ Relationship _____ Date of Birth _____

Employer Name (if applicable)

Work Phone _____

TOTAL FAMILY INCOME

LAST 12 MONTHS

Wages	\$ _____
Unemployment Benefits	\$ _____
Disability Benefits	\$ _____
Social Security Benefits	\$ _____
Public Assistance	\$ _____
Child Support/Alimony	\$ _____
Dividends, Interest, Rent Income	\$ _____
Other Income _____	\$ _____

Total Gross Income: \$ _____

I understand that the information requested by the Catholic Health System concerning my annual income, employment, property and family size is subject to verification. I also understand that if the information submitted is determined to be untrue, such determination will result in a formal denial and the guarantor will be liable for all charges.

I hereby certify that all of the information in this application or attached thereto is true and correct to the best of my knowledge. I agree to give notification of any change in my income status within ten (10) days of such change.

(Signature of Applicant)

(Date)

**Verification of income may include copies of:
SSA 1099 Form and/ or Income tax filing from prior year.**