



Self-Declaration Form

INCOME INFORMATION

In order for FHS to help our patients we must ask everyone to complete the following information. This is requested of you so that FHS can receive Federal grant dollars to serve our patients. We appreciate your cooperation. All information is kept confidential and is used for reporting purposes only.

Total Number of people in your household, including yourself: _____

Total Household income: (Please check the amount that best describes the total income in your household)

Less than \$11,000 \$30,001-\$35,000 \$55,001-\$60,000

\$11,001- \$15,000 \$35,001- \$40,000 \$60,001-\$65,000

\$15,001- \$20,000 \$40,001- \$45,000 \$65,001- \$70,000

\$20,001- \$25,000 \$45,001- \$50,000 \$70,001- \$75,000

\$25,001- \$30,000 \$50,001- \$55,000 Greater than \$75,000

VETERANS / MILITARY STATUS

Is or was the patient ever a member of the US military or is the patient an US veteran?

Please check one: YES NO

FINANCIAL ASSISTANCE (Optional)

Yes, I authorize FHS to release my contact information to Certified Application Counselors who may be able to assist me with insurance coverage. I understand enrollment is based on eligibility.

I am interested in learning more about FHS's Sliding Fee Program

Please sign and date below.

Signature (Patient/Parent or Guardian): _____

Date: _____

No, I am not interested.