



Source of Income	You	Spouse Or Partner	Children	Other	Frequency (circle one)
Salaries/Wages					Weekly Bi-Weekly Monthly Yearly
Social Security					Weekly Bi-Weekly Monthly Yearly
Public Assistance					Weekly Bi-Weekly Monthly Yearly
Unemployment					Weekly Bi-Weekly Monthly Yearly
Retirement/Pension					Weekly Bi-Weekly Monthly Yearly
Child Support					Weekly Bi-Weekly Monthly Yearly
Alimony Support					Weekly Bi-Weekly Monthly Yearly
Disability Income					Weekly Bi-Weekly Monthly Yearly
Worker's Compensation					Weekly Bi-Weekly Monthly Yearly
Other _____					Weekly Bi-Weekly Monthly Yearly

I declare the above information is accurate and I grant Isabella Citizens for Health, Inc. permission to verify any information provided in this application. I understand that this information is kept in the strictest confidence. I also understand that should my income change, I am required to notify the appropriate health center staff member before or at my next Center visit. Appropriate staff may include a receptionist, billing staff person, pharmacy staff person or School-based staff person.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

*Do not write below this line. For office use only.*

Approved/Denied Effective Date: \_\_\_\_\_ Income Level: \_\_\_\_\_

Explanation for denial: \_\_\_\_\_

CEO Approval/Denial: \_\_\_\_\_ Date: \_\_\_\_\_

Date Patient Informed: \_\_\_\_\_ Informed By: \_\_\_\_\_

Informed How: \_\_\_\_\_