FAMILY ASSISTANCE PLAN APPLICATION

Name of head of house hold		Place of Employment		
Street	City	State	Zip	Phone
Health Insurance Plan		Social Security Number		

FAMILY ASSISTANCE PLAN APPLICATION

I decline to apply for Sliding Scale Fee discounts and agree to pay a minimum fee of $ 70.00

Name (print) X _____ Date _____

Name (signature) X _____ witness _____

please list spouse and dependants under age 18

	NAME	DATE OF BIRTH		NAME	DATE OF BIRTH
SELF			DEPENDANT		
SPOUSE			DEPENDANT		
DEPENDANT			DEPENDANT		
DEPENDANT			DEPENDANT		

Annual House Hold income

source	self	spouse	other	total
Gross wages, salaries, tips, etc...				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self employment, and dependants				
Rent, interest, dividend, and other income				
Total income				

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Name of head of house hold		Place of Employment		
Street	City	State	Zip	Phone
Health Insurance Plan		Social Security Number		

FAMILY ASSISTANCE PLAN APPLICATION

I decline to apply for Sliding Scale Fee discounts and agree to pay a minimum fee of $60.00.

Name (print) _____ Date_____

Name (signature)_____ witness_____

please list spouse and dependants under age 18

	NAME	DATE OF BIRTH		NAME	DATE OF BIRTH
SELF			DEPENDANT		
SPOUSE			DEPENDANT		
DEPENDANT			DEPENDANT		
DEPENDANT			DEPENDANT		

Annual House Hold Income

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