HRSA Sliding Discount Income Verification Form

Please use this form as a guide. Bring this form back to the clinic when complete.
Provide documentation of income for the past 30 days. If self-employed, please provide tax returns for most recent year.

Patient Name: _____

Application Due Date: _____

Income Source	Household Member Receiving Income	Monthly Gross Amount
Wages/Pay Stubs		
Retirement		
Unemployment		
Social Security		
Disability/SSI		
Alimony		
Child Support		
Foster Care		
AK Temporary Assistance Program (ATAP)		
Worker's Compensation		
AK Senior Benefit		
Interest Income		
Rental Income		
Dividends (excluding PFD and Native Corp. dividends up to $2500)		
Other Income		
	Total	**$**

If you have no income, please explain how you are meeting your living expenses: