Wood County Community Health Center
Sliding Fee Application Form

Head of Household Name:		Birthdate:
Street Address:		Social Security Number:
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Household Members		
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Name:	Relationship:	Birthdate:
Income Documentation(list and attach):		
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I understand that providing false information may result in legal action, and attest that all of the information that I have provided is true and correct to the best of my knowledge.		
Signed:		Date:
Witness:		Date:
Wood County Community Health Center Only		
Reviewer Notes:		
Date of Evaluation:	Annual Income:	Discount Percentage:
Reviewer Signature:		Date:

This proof of income is valid one year from the date of evaluation.