Clay-Battelle Health Services Association

This form must be returned to the Clay-Battelle Community Health Center within *10 days* in order for any discount to be applied to your account.

Sliding Fee Application

Name:_____
Last First Middle

Address:_____ _____
Street PO Box

_____ _____ _____
City State Zip

Phone:(_____)_____

#Of People in Household_____

List Names	Date of Birth	Relationship
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Total Annual Income_____ or Total Monthly Income_____

Patient Signature:_____Date:_____

Reviewed by:_____Date:_____

Office use Only:

Medical Slide
B C D

Dental Slide
B C D

Expiration Date
_____

Verification Codes:
1. Form 1040
2.W2
3.Wage Statement
4. Health Center Employee Knowledge
5.Other