KNOX COMMUNITY HEALTH CENTER
1361 West Fremont Street Galesburg, Illinois 61401
309.344.2225

Sliding Fee Scale Eligibility Form

It is necessary for us to ask personal questions in order to qualify you for a discount on our medical/dental expenses. This information will be kept on file in our center in strict confidence. You must verify your income at least annually. Your yearly income tax return with a copy of your W-2 form, payroll check stubs covering the past six months, or copies of your social security checks, or other checks you may receive may be sufficient proof. Your annual income will be used to calculate the level of your payment.

Name:

Date of Birth: **Today's Date:**

Household Income?	**You**	**Your Spouse**	**Your Children**	**Other Person**	**Total Family Income**

Place of Employment?	**You**	**Your Spouse**	**Your Children**	**Other Person**

How many people live in your home? _____ **Is your principal employment in agriculture?** **Yes ❒** **No ❒**

Do you receive any income from any of the following sources; and if so, how much?

Sources	**You**	**Your Spouse**	**Your Children**	**Other Person**	**Total Family Income**
Social Security Income					
Public Assistance					
Retirement Pension					
Food Stamp Income					
Rental Income					
Interest Income					
Child Support, Alimony					
Other, _____					

Please list the Names, Date of Birth, and Social Security Number for all people in your household:

Name:	**Date of Birth:**	**Social Security Number:**

I declare the above information is true and give the Knox Community Health Center (KCHC) permission to investigate any information provided in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the community health center.

I hereby authorize payment to the KCHC and its contracted provider for usual and customary costs of treatment payable by any insurance I have; but, not to exceed KCHC schedule of charges. I understand that I am responsible to KCHC and its contracted providers for any charges not covered by any insurance I have.

Authorizing Signature:	**Date:**	**Clinic Purposes Only** **SFS Code:**