Dear Foremost Family Health Centers Patient,

On behalf of myself, the Board of Directors, management, the healthcare team and staff of the Foremost Family Health Centers (FFHC), I would like to take this opportunity to welcome you to our group. I am delighted you chose one of our physicians/providers to care for you and your loved ones. We are all personally committed to providing the highest quality care and exceptional customer service for you and your family. Our goal is to become your primary care medical and dental provider and medical home.

A medical home is a place where you receive health care that revolves around you. Caring about you is the most important job of a medical home. You and your health care are at the center of your medical home team. The care you receive in your medical home is personalized to your individual need and our health team’s job is to make sure you get the health care services you need.

Our physicians, providers and dentists are unique to Dallas/Fort Worth Metroplex because we focus on providing primary care through the following specialties: Pediatrics, Family Medicine, Obstetrics, Gynecology, Behavioral Health, Podiatry, and Dental Services. This allows us the ability to serve you and your family at every stage of your life. We have arrangements with a network of specialists and hospitals if we need to refer you to other services. In addition, we have competitive rates and offer discounts to those who meet eligibility requirements.

We strive to be progressive in our use of information technologies to include electronic medical records and online communication. Our advanced systems provide you easy access to our physicians and providers for appointments and timely medical and dental advice. For more information, please review our web site at www.foremostfhc.org. Again, thank you for choosing Foremost Family Health Centers.

Sincerely,

Joyce Tapley, MHA, CHCO, OHCC, CHA, CIFHA
Chief Executive Officer
### Patient Demographic Form

#### Patient's Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Birthdate</th>
<th>Sex Assigned at Birth</th>
<th>Mother's First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male □ Female □</td>
<td>(For Immunization Registry Only)</td>
</tr>
</tbody>
</table>

#### Patient's Billing/Mailing Address

<table>
<thead>
<tr>
<th>Street or PO Box</th>
<th>Patient's Physical Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(if different from billing/mailing address)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zipcode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Patient's Contact Information

<table>
<thead>
<tr>
<th>Mobile Phone #</th>
<th>Day Phone #</th>
<th>Alternate Phone #</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Preferred Method for Notifications (check all that apply)

- □ Phone
- □ Text
- □ Email
- □ Automated Recordings

#### Patient's Emergency Contact Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Patient's Additional Information

- Race (you may mark more than one)
  - □ American Indian/Alaskan Native
  - □ Asian
  - □ Black/African American
  - □ Native Hawaiian
  - □ Other Pacific Islander
  - □ White

- Are you of Hispanic or Latino origin?
  - □ Yes
  - □ No

- Primary Language
  - □ English
  - □ Spanish
  - □ Other ______________________

- Are you a Veteran?
  - □ Yes
  - □ No

- Marital Status
  - □ Single
  - □ Married
  - □ Divorced
  - □ Widow
  - □ Separated
  - □ Life Partner
  - □ Other ________

- Households Size
  - □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

- Estimated household income
  - □ Weekly
  - □ Bi-Weekly
  - □ Monthly
  - □ Annually

- Current Gender Identity
  - □ Male
  - □ Female
  - □ Transgender Male (FTM)
  - □ Transgender Female (MTF)
  - □ Genderqueer, neither exclusively male nor female
  - □ Decline to Answer
  - □ Other (please specify) ______________________

- Sexual Orientation
  - □ Straight or Heterosexual
  - □ Lesbian, Gay or Homosexual
  - □ Bisexual
  - □ Something Else
  - □ Don't Know
  - □ Decline to Answer

- Housing Status
  - □ Current Resident of Public Housing
  - □ Homeless ______ Doubling Up □ Shelter □ Transitional □ Unknown/Other ________
  - □ Not Homeless and Not Current Resident of Public Housing

- How did you hear about us?
  - □ Billboard
  - □ Employee
  - □ Facebook
  - □ Health Fair
  - □ Radio
  - □ Family/Friend
  - □ Insurer
  - □ Website
  - □ Signage
  - □ Community Agency
  - □ Television
  - □ Other (please specify) ______________________
## Primary Insurance

<table>
<thead>
<tr>
<th>Type of Primary Coverage</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Private Insurance</th>
<th>None</th>
<th>Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Insurance Company</th>
<th>Policy Number</th>
<th>Group Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address of Insurance Company (Street, City, State, and Zip)</th>
<th>Effective Date</th>
<th>Expiration Date</th>
</tr>
</thead>
</table>

## Secondary Insurance (if applicable)

<table>
<thead>
<tr>
<th>Name of Insurance Company</th>
<th>Policy Number</th>
<th>Group Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address of Insurance Company (Street, City, State, and Zip)</th>
<th>Effective Date</th>
<th>Expiration Date</th>
</tr>
</thead>
</table>

## Signature

I, the undersigned, understand that the information on this form is confidential. I certify that the information contained on this form is correct to the best of my knowledge.

Patient Signature ____________________________ Date ____________
Patient Name: __________________________________________________________

Patient Date of Birth: _________________

Patient confidentiality is a top priority at Foremost Family Health Centers. Therefore, it is important that you provide us with the following information to ensure that there is no violation of your privacy.

Foremost Family Health Centers staff may leave messages regarding results (test/lab), scheduling (appointment, surgery, and procedure) and billing information with the following:

- □ Spouse (Please specify name)__________________________________________
- □ Voicemail at work
- □ Voicemail at home
- □ Voicemail on cell phone
- □ Other - Describe: ____________________________________________________
- □ Foremost Family Health Centers staff MAY NOT leave any information.

Please list any family members/ persons who may obtain or call and discuss your medical information:

___________________________________________ ___________________________
Name (First and Last)                      Relationship

___________________________________________ ___________________________
Name (First and Last)                      Relationship

___________________________________________ ___________________________
Name (First and Last)                      Relationship

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff at Foremost Family Health Centers.

Patient Signature____________________________________________________ Date________
NEW PATIENT HISTORY FORM

PLEASE BRING THIS COMPLETED FORM WITH YOU TO APPOINTMENT

Name: _________________________________  Birthday: ____________
Reason for visit today: ___________________________  Today’s Date: __________
Previous Provider/ Clinic: __________________________________________________

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction

PAST MEDICAL HISTORY

Do you now or have you ever had the following conditions:

- Diabetes
- High blood pressure
- High cholesterol
- Hypothyroidism
- Goiter
- Cancer (type) _________________
- Leukemia
- Psoriasis
- Angina
- Heart problems
- Bronchitis

Other medical conditions (please list):
________________________________________________________________________
________________________________________________________________________

Please list any surgeries (operations), reason for the surgery, and date of surgery:

TELL US ABOUT YOURSELF:
Home situation (circle, or add in writing):

Single_____  Married (how long____)  Divorced (how long____)  Widowed (how long____)

Domestic partnership____  Children____  Are they healthy?___________

Employment:
Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Occupation/type of work/jobs: __________________________________________________
FAMILY HISTORY:
Place an “X” in appropriate boxes to identify all illnesses/conditions in your blood relatives

<table>
<thead>
<tr>
<th>Illness/Condition</th>
<th>Family Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>grandparents</td>
</tr>
<tr>
<td>Cancer</td>
<td>X</td>
</tr>
<tr>
<td>Kidney problems</td>
<td>X</td>
</tr>
<tr>
<td>Heart disease</td>
<td>X</td>
</tr>
<tr>
<td>Diabetes</td>
<td>X</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>X</td>
</tr>
<tr>
<td>Liver disease</td>
<td>X</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>X</td>
</tr>
<tr>
<td>Alcohol/drug abuse</td>
<td>X</td>
</tr>
<tr>
<td>Depression/psychiatric illness</td>
<td>X</td>
</tr>
<tr>
<td>Genetic (inherited) disorder</td>
<td>X</td>
</tr>
<tr>
<td>Other</td>
<td>X</td>
</tr>
</tbody>
</table>

SUBSTANCE USE

<table>
<thead>
<tr>
<th>DRUG CATEGORY</th>
<th>Age when you first used this:</th>
<th>How much &amp; how often did you use this?</th>
<th>How many years did you use this?</th>
<th>When did you last use this?</th>
<th>Do you currently use this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOBACCO: cigarettes, cigars, chew</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALCOHOL: beer, wine liquors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>CANNABIS: Marijuana, hashish, hash oil</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>STIMULANTS: Cocaine, crack, methamphetamine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>NARCOTICS: heroin, opiates, pain pills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>OTHER: __________________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
# Pregnancies:
# Miscarriages: # Abortions:
Have you reached menopause? Y / N At what age? __________
Do you have regular periods? Y / N Date of last period? ______________
Dear Foremost Family Health Centers Patients,

Foremost Family Health Centers (FFHC) would like to take this opportunity to welcome you to our family. We are delighted you chose our facility for your medical and dental care services. Our goal is to become your medical and dental home.

FFHC strongly affirms your right to make decisions regarding your medical care, including the right to select the provider you want to give you medical care. The choice of provider is expressly guaranteed by legal and ethical considerations. At FFHC, we give our patients the opportunity to exercise the freedom of choice of healthcare provider free from coercion or interference. Attached is a provider list.

You can choose from several types of providers at FFHC:

- **Family Practitioners** -- doctors who have completed a family practice residency and are board certified, or board eligible, for this specialty. The scope of their practice includes children and adults of all ages and may include obstetrics and minor surgery.

- **Pediatricians** -- doctors who have completed a pediatric residency and are board certified, or board eligible, in this specialty. The scope of their practice includes the care of newborns, infants, children, and adolescents.

- **Obstetricians/gynecologists** -- doctors who have completed a residency and are board certified, or board eligible, in this specialty. They often serve as a PCP for women, particularly those of childbearing age.

- **Nurse Practitioners** -- nurses with a graduate degree in advanced nursing. They are licensed by the state and allowed to provide a broad range of health care services. They can serve as a primary care provider in family medicine (FNP), pediatrics (PNP), adult care (ANP), or geriatrics (GNP). Others are trained to address women's health care (WHNP) and family planning. NPs can prescribe medications.

- **Dentists** -- doctors who have completed and obtained a degree of doctor of dental science (DDS), and skilled in and licensed to practice the prevention, diagnosis, and treatment of diseases, injuries, and malformation of the teeth, jaws and mouth.
Thank you for choosing Foremost Family Health Centers as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy. **All patients must read and sign this form prior to receiving services.**

1. **It is your responsibility to provide us with your most current insurance information.**

2. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered. We must emphasize that, as medical providers, our relationship is with you, the patient, and not with your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

3. If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage may result in full financial responsibility for services rendered.

4. We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are then financially responsible for services not covered by your insurance company.**

5. Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, a requirement by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

6. We charge what is usual and customary for our area. You may be responsible for payment in addition to insurance coverage.

7. Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim—regardless of our estimation.

8. **It is your responsibility to provide us with your most current billing information.**

9. You must provide your most current billing address, all available telephone numbers, and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.

10. We will send a statement to the billing address you provide notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement.

11. **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. You may request a payment plan.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, RIGHTS & RESPONSIBILITIES, ADVANCE DIRECTIVE INFORMATION

I have been provided a copy of the Notice of Privacy Practices, Patient Rights & Responsibilities, and Information on Advance Directives. This document provides me with a more complete description of the uses and disclosures of certain health information and my rights / responsibilities as a patient. I understand that Foremost Family Health Center (FFHC) reserves the right to change their Notice of Privacy Practices and Rights & Responsibilities, and prior to implementation, will provide an updated copy on the clinic website, www.foremostfhc.org, and in the provider’s office. I may request a copy of the update Notice of Privacy Practices by calling FFHC or requesting a copy in person at my appointment.

Patient / Legal Representative Signature ___________________ Relationship to Patient ________________ Today’s Date ________________

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my Physician, Dentist, Nurse practitioner, behavioral health provider, case manager and other individuals deemed appropriate to perform and/or order exams, tests, procedures, referrals and any other care considered necessary or advisable for the diagnosis and treatment of my medical or dental condition. Lab testing may include (but is not limited to) glucose, cholesterol, TB, HIV (ages 13 – 64), CBC, and other tests. This consent is valid for each visit I make to the Foremost Family Health Centers unless revoked by me orally or in writing.

Please be informed that Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient’s blood or body fluids, such as through a needle stick (any such tests shall be conducted pursuant to the FFHC’s infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient’s blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of FFHC if any of these situations occur during your treatment period.

Patient / Legal Representative Signature ___________________ Relationship to Patient ________________ Today’s Date ________________

ACKNOWLEDGEMENT OF FINANCIAL POLICY

A payment, co-payment or deductible, may be required at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy. I understand that I may be eligible for a discount if I provide all necessary information requested, and qualify under the federal guidelines.

Patient / Legal Representative Signature ___________________ Relationship to Patient ________________ Today’s Date ________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Foremost Family Health Centers to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical / dental benefits to FFHC. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my provider, based on his/her discretion, to access my chart for utilization management review.

Patient / Legal Representative Signature ___________________ Relationship to Patient ________________ Today’s Date ________________

I have witnessed the patient or legal representative review and sign the Patient Signature Page

FFHC Employee (Witness) ___________________ Employee’s Name Printed ___________________ Today’s Date ________________
Dear Foremost Family Health Centers Patients:

Thanks for choosing Foremost Family Health Centers (FFHC) as your medical home. As a patient and a partner in your health care, we would like you to take advantage of our patient portal.

The patient portal enables patients to:

- Communicate with our practice, securely and efficiently
- Send email and secure messaging for non-urgent needs
- View some of your Personal Health Records
- Review some laboratory results
- View financial statement
- Request an appointment, and see the date and time of upcoming appointments
- Request prescription refills
- Request referrals
- Update your demographic information (i.e. address, phone number, insurance)
- Request information.

Note: Sensitive matters will not be communicated through the portal (ex. HIV status, mental health, etc.).

The Patient Portal is NOT for urgent communications. FFHC will maintain and manage the patient portal, including any patient requests made through the patient portal, during our normal business hours. Please allow up to 3 business days for us to reply.

If your matter is urgent, please call us at (214) 426-3645 during office hours and (214) 360-2963 after-hours. For life-threatening conditions call 911 or go to the nearest emergency room immediately.

All portal functions may not be available to you. Function availability will be based on guidelines from HIPAA, and laws regarding protected health information. All communication via the patient portal is private, secure and will be included in your permanent patient record.
I understand that the patient portal is a secure way to have access to my provider, the health team and the center as part of the services offered to me by Foremost Family Health Centers (FFHC), my medical home. By registering and signing this consent form, I agree to the terms of the portal use and will follow all policies and procedures.

I understand that this agreement will remain in effect for twelve (12) months. At the end of that time, I may be asked to renew my confidential email account and Patient Portal Login. My login and password is confidential, so I will not give this information to anyone. It is my responsibility to notify Foremost Family Health Centers if there is a change in my email account or I feel that my secure password has been breached.

Please Print Clearly

Name: (First, MI, Last)_______________________________Date of Birth _______________

Address_______________________________________________Apt/ Unit # ____________

City____________________State_______________________ZipCode __________

Confidential email address__________________________________________________________

Confirm email address_____________________________________________________________

Signature ___________________________ Date__________________________

After registration and signing this consent form, your information will be placed in the portal system and you will be sent an email welcoming you to the patient portal. In addition, this email will provide you information about your user identification, temporary password, how to change your password, how to use the portal and other information for you to be successful in using this tool for communication with your provider, the health team, and clinic.
**Sliding Fee Registration Form**

**Foremost Family Health Centers (FFHC)**  
Post Office Box 150128  
Dallas, Texas 75215

---

**Sliding Fee Eligibility Form**

It is necessary for us to ask personal questions in order to give you a discount for FFHC services. This information will be kept on file in strict confidence.

Your income and family size will be used to calculate the level of discount. You must verify your income at least annually, or if your income changes.

---

Today's Date: ___________  
Number of family members living in your home? ___________

What is your marital status?  
- [ ] Married  
- [ ] Widow(er)  
- [ ] Single  
- [ ] Divorced  
- [ ] Separated

<table>
<thead>
<tr>
<th>Place of Employment?</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td></td>
</tr>
<tr>
<td>Your Spouse</td>
<td></td>
</tr>
<tr>
<td>Your Children</td>
<td></td>
</tr>
<tr>
<td>Other Person</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

---

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

<table>
<thead>
<tr>
<th>Sources</th>
<th>You</th>
<th>Your Spouse</th>
<th>Your Children</th>
<th>Other Person</th>
<th>Total Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Assistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement Pension</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rental Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Support, Alimony</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any type of insurance?  
- [ ] Yes, list below  
- [ ] No

<table>
<thead>
<tr>
<th>Amount of Household Income?</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

---

I declare the above information is true and have given FFHC permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change I am required to notify FFHC on my next visit.

Patient Signature:  
Date:

Employee Signature:  
Date:  
Clinic Purpose Only  
Income Code:
Verification must be provided to confirm income, family size and proof of address. Below is a listing of items accepted as verification documents. One item from each category is required.

**INCOME**
- W-2 withholding statements or signed income tax return from most recent year
- Three recent paycheck stubs with year-to-date totals, including tips
- Current forms/letters from Medicaid, other state-funded medical assistance, or other government agency (Social Security, WIC, Social Services, Disability, VA, Child Support Award Letter)
- Letter from employer on company letterhead
- Texas Workforce Commission Documentation
- Proof of catastrophic situations (death or disability in family, divorce, homelessness) or other documentation that shows that the patient would be unable to pay the medical bill and still pay for other basic necessary expenses
- Signed declaration of no income
- School schedules, for students with no income

**FAMILY SIZE**
- Rental & Lease Agreement listing people in household
- Birth certificates of dependent children or Social Security Cards for all family members
- Income tax return, listing dependents
- Letter from shelter
- Current forms/letters from Medicaid, other state-funded medical assistance, or other government agency (Social Security, WIC, Social Services, Disability, VA, Child Support Award Letter)
- Other legal/verifiable documents

**PROOF OF ADDRESS**
- Utility bill
- Photo ID with current address
- Proof of car insurance
- Current forms/letters from Medicaid, other state-funded medical assistance, or other government agency (Social Security, WIC, Social Services, Disability, VA, Child Support Award Letter)
- Lease and/or Mortgage agreement
- Other government or verifiable document
- Letter from family member with whom you currently live

Eligibility is based upon income and family size. Please note that if you do not qualify for the sliding fee discount, or are unable to provide the requested documentation, you will be responsible for paying full price.
Please list the name of all family members who reside in the home in the area below.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>DOB</th>
<th>SS#</th>
<th>Proof Document</th>
</tr>
</thead>
<tbody>
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