Pasadena Health Center **Application: Sliding Fee Scale**
908 Southmore, Suite 100, Pasadena, Tx 77502 **Phone: 713-554-1091**

Please use black ink and print. (Do not use white-out, pencil, or colored inks)
Strike out and initial mistakes. (e.g.)

Head of Household: DOB:		Place of Employment:
Address: number, street, city, state, zip		Work Phone:
Home Phone:	Social Security Number:	Health Insurance:

Please list spouse/partner and dependents under age 18					
Name		Date of Birth	Name		Date of Birth
Spouse/Partner			Dependents		
Dependents			Dependents		
Dependents			Dependents		
Dependents			Dependents		

Annual Household Income				
Source	Applicant	Spouse	Other	Total
Wages, salaries, tips, etc				
Social security, pension, annuity, and veterans benefit				
Income from business self employment, and dependents				
Unemployment, workers compensation, strike benefits, etc				
Rent, interest, dividend, and other income				
Total				

Verification Checklist (attach copies)	**Yes**	**No**
Identification/Address: Drivers license, birth certificates, employment ID, social security card, other		
Income: prior year tax return, most recent pay stubs, bank statement, other		
Insurance: Insurance cards		
Medicaid: Application made or evidence of rejection		

I certify that the information shown above and understand verification is required for approval.

Name _____ Signature _____ Date ___/___/___

Pay class approved Tier_____ Effective Date Recertification Date