

Household Income					
Name	Amount	Frequency (Circle One)		Employer:	
You	\$	Weekly Yearly	Monthly		
Spouse	\$	Weekly Yearly	Monthly		
Children	\$	Weekly Yearly	Monthly		
Other	\$	Weekly Yearly	Monthly		
	\$	Weekly Yearly	Monthly		
TOTAL	\$	Weekly Yearly	Monthly		
Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	\$

NOTE: To comply with federal regulations, in order to give you a discount on your therapy services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Your yearly income tax return, a copy of your W-2 form, last month’s paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

I do hereby swear or affirm that the information provided this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program. I further agree to inform Dunamis Center, Inc. if there are any significant changes in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Dunamis Center, Inc.. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____

Name (Print): _____

Signature: _____

****Please bring application to your appointment or fax it back at 530-338-0087**