South Routt Medical Center Health Service District

300 Main Street / P.O. Box 8/ Oak Creek, CO 80467/Phone (970) 736-8118/Fax (970) 736-0678

ELIGIBILITY FORM

Please fill this form out completely or it will not be processed. Please print clearly.

Head of household: ______________________ S.S.N. ______________________ D.O.B. __________
Name of Spouse: ______________________ S.S.N. ______________________ D.O.B. __________
Household address: ______________________________________ Apt. #: __________
P.O. Box: ____________ City: ______________________ Zip Code: ______________
Home Phone #: ____________ Cell Phone #: ______________ Work Phone #: ______________
Employer Name/Address: ____
Spouse Employer Name/Address: ____
Spouse Work Phone: ______________________ Message Phone #: ______________
Number of Family Members: Adults: ______________ Children: ______________
Monthly Household Income: $ ______________________
Name of Insurance Company: ______________________ Group #: ______________
Race/Ethnicity:

( ) Caucasian, White or European
( ) Hispanic or Latino (a)
( ) Native American or American Indian
( ) African American or Black
( ) Asian American, Asian or Pacific Islander
( ) Mixed Heritage
( ) Other

Child's Name	Gender	Social Sec. #	Date of Birth	Name of School	Grade

In order to process this form, supportive documentation of income is required.
Acceptable forms of proof of income:

- Two consecutive months of paycheck stubs for all family members OR
- Last years' 1040 Federal tax Form OR
- A signed letter from Employers(s) on Company Letterhead indicating hours worked and salaries received.

PLEASE CHOOSE ONLY ONE:

( ) Paycheck Stubs ( ) 1040 Tax Form ( ) Signed Letter from Employer on Company Letter Head

I affirm that the information I have furnished is true and correct. I understand that withholding or falsifying any information on this form or in its supportive documents may cause dismissal of my family from South Routt Medical Center's sliding fee scale program.

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Signature Date