LK HEALTH

LK Health
901 W. Whittier Blvd.
Montebello, CA 90640
(323) 728-8588
www.lkmed.org

Sliding Fee Scale Application

I. Applicant Name (Print): ______________________________ DOB: ______________

II. Household Size Information
(Household members include those persons living in the same home who are related by birth, marriage, registered domestic partnership, or adoption.)

Please list below **all** members of your household, including yourself.

	Name	Relationship	Date of Birth		Name	Relationship	Date of Birth
1.				5.			
2.				6.			
3.				7.			
4.				8.			

III. Household Income Information

Please list below all sources of income for all adult members of your household, including yourself.
Adults are considered those persons 18 - years and older. Please attach to this application verification of each source.

Name	Relationship	Source of Income	Amount Received	Frequency (weekly, biweekly, monthly, yearly)	Office Use Only TOTAL

DECLARATION

Completion of this application and income verification are necessary to participate in LK Health's services. I understand that LK Health cannot guarantee services provided outside of the LK Health clinic to be free. I will be responsible for the bills incurred in receiving healthcare not provided by LK Health. By signing below, I attest that everything listed in this application is true and accurate.

Print Name: ______________________ Signature: ____________________________

Relationship (if not applicant): ____________________ Date: ______________________