# Siskiyou Community Health Center

**Thank you for choosing Siskiyou Community Health Center as your medical home.**

*What are the steps to becoming a new medical patient?*

1. Come in to one of our medical sites Monday – Friday between 8 – 12pm and 1 – 4pm and ask to speak to our Patient Service Coordinator.

2. Our Patient Service Coordinator will go over our New Patient Registration Packet with you and answer any questions you may have.

3. Complete the New Patient Application. If you would like to apply for our Sliding Discount Program, the application will be given to you along with the guidelines for acceptable proof of income. The application and proof will need to be completed by your first appointment.

4. Complete a Records Release so that we may obtain your medical records for the last five (5) years. These records are a necessary part of providing quality care and may be required prior to setting up an appointment. Requests for past records are faxed upon receipt of the signed Records Release and often take up to thirty (30) days to receive.

5. Once the registration process is complete, the Patient Service Coordinator will contact you to schedule an appointment.

*What do I need to bring to my first appointment?*

- Picture ID, state issued and current (ex: driver's license, ID card, or passport).
- Insurance card, if applicable.
- The names and phone/fax numbers of any medical provider that you have seen in the last five years.
- All medications you currently take both prescribed and over-the-counter, including supplements and vitamins.
- Completed slide application and acceptable proof of income, if applying for our Sliding Discount Program.
- Any paperwork that was given to you and asked to be returned at your visit.

**CONSENT TO SHARE MEDICAL INFORMATION**

If you as a Patient need to have someone help you with making appointments or requesting information that has to do with your health care, you will need to sign an *Authorization to Release and Exchange Medical Information* form. Please ask to complete the authorization so that we can accommodate your needs.

*Please note: Our providers are unable to refill MEDICATION until you have become an established patient.*

Siskiyou Community Health Center

# NOTICE: PATIENT PRIVACY

We are required by law to protect the privacy of your medical information and to provide you with written Notice describing:

## HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

- We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

- We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

- As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

- We have available a detailed **NOTICE OF PRIVACY PRACTICES** which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the bottom right hand side of this page indicates the date of the most current NOTICE in effect.

- You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

- If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact the HIPAA Privacy Officer at 1-866-667-2870.

# Siskiyou Community Health Center


❒ **GRANTS PASS MEDICAL**
1701 NW Hawthorne Ave
Grants Pass, OR 97526
Phone: (541) 471-3455
Fax: (541) 471-1439

❒ **CAVE JUNCTION MEDICAL**
25647 Redwood Highway
Cave Junction, OR 97523
Phone: (541) 592-4111
Fax: (541) 592-3916

❒ **GRANTS PASS DENTAL**
1701 NW Hawthorne Ave
Grants Pass, OR 97526
Phone: (541) 479-6393
Fax: (541) 479-6489


## PRESCRIPTION REFILL POLICY

We at Siskiyou Community Health Center are committed to providing excellent health care. We want to simplify the process to get you the medications you need in a timely manner.

We ask that you:

- **Bring all your medications to each visit, unless told differently by your Provider.**
- **Let the Medical Assistant and Provider know how many refills you will need to last until your next scheduled appointment.**
- **For new medications, ask for enough refills to last until your next appointment.**

Whenever you get your medication refilled at the pharmacy, check to see if you have any more refills left. If not, call us to schedule an appointment with your Provider. In most cases, if you need refills, we will ask you to come for an appointment.

If we are unable to get you an appointment before you will run out of your prescription, we will ask that you contact your pharmacy to fax us a refill request. Please allow three (3) business days for this process. If your request is on a Friday, it may not be ready until the following Wednesday.

You will still need to make an appointment to see your Provider for any more refills.

If you have a medication agreement with your provider for a narcotic or other controlled medications, follow the requirements of the agreement. If you do not know the requirements, ask for another copy of your agreement and discuss it with your Provider at your next appointment.

Thank you for your cooperation.

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❒ **GRANTS PASS DENTAL**
1701 NW Hawthorne Ave
Grants Pass, OR 97526
Phone: (541) 479-6393
Fax: (541) 479-6489

❒ **MEDFORD HEALTHY FAMILIES**
1380 Biddle Road, St. D
Medford, OR 97504
Phone: (541)-500-8407


**A new Federal Regulation has been adopted that is designed to protect patients from Identity Theft which is named the "Red Flag Rule." This rule states that medical offices are required to obtain a copy of a government-issued photo ID to protect patient from possible identity theft. Examples are: Driver's License, Military ID card, Passport, or State-issued ID card. Please bring your photo ID to your next appointment so we can place a copy in your chart. Thank you.**

# SISKIYOU COMMUNITY HEALTH CENTER

## Patient Registration

Welcome to Siskiyou Community Health Center. We are committed to providing quality, cost-effective health care for you and your family. Please feel free to speak with your provider if you have any questions about your care. If you have any questions about clinic policies or procedures, please speak with the clinic manager.

## 1 PATIENT DEMOGRAPHICS

Full Name _____ Nickname _____

SSN_____ Date of Birth_____ Birth Sex ☐Female ☐Male

Billing Address _____ City_____ State_____ Zip_____

Home Address _____ City_____ State_____ Zip_____

Home Phone _____ Day Phone _____ Cell Phone _____

Preferred Notification for Reminders ☐ Phone Call ☐ Text Message ☐ Opt Out (No Reminders)

Emergency Contact Name/Relationship _____ Phone_____

Marital Status ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐Domestic Partner

Primary Language ☐English ☐Spanish ☐Sign Language ☐Other_____Do you need an interpreter? ☐Yes ☐No

Name of Spouse/Significant Other**_____

SSN_____ Date of Birth_____ Phone _____

***If you would like this person to be able to discuss your medical care and/or billing issues, please request an Authorization Form.***

Primary Pharmacy_____ Secondary Pharmacy _____

## 2 INSURANCE INFORMATION - Please provide your insurance card(s)

Name of Primary Insurance_____ Policy #_____

Policyholder Name_____ Date of Birth_____

Name of Secondary Insurance_____ Policy #_____

Policyholder Name_____ Date of Birth_____

## 3 MINOR PATIENTS ONLY

Mother's Name_____Date of Birth_____ SSN_____

Address_____ Phone_____

Father's Name_____ Date of Birth_____ SSN_____

Address_____ Phone_____

## 4 PATIENT STATISTICS

As a Federally Qualified Health Center, we are able to offer services to all our patients, including the underserved, as a result of funding from Federal Grants. In order to receive grant dollars we are required to gather, on a yearly basis, statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

**What is your living status?** ☐Homeless ☐Not Homeless **Are you a Migrant Farm Worker?** ☐Yes ☐No

**What is your Race?** ☐White ☐American Indian/Alaska Native ☐Asian ☐Black/African American
*(mark all that apply)* ☐Native Hawaiian ☐Pacific Islander

**What is your Ethnicity?** ☐Not Hispanic/Latino ☐Hispanic/Latino **Are you a Veteran?** ☐Yes ☐No

**Gender Identity?** ☐Declined ☐Female ☐Male ☐Transgender F to M ☐Transgender M to F ☐Genderqueer ☐Other

**Sexual Orientation?** ☐Declined ☐Straight/Heterosexual ☐Lesbian/Gay ☐Bisexual ☐Something Else ☐Don't know

**What is your Gross Annual Household Income?** _____ **How many people are in your household?** _____

**What is your employment status?** ☐Employed ☐Homemaker ☐Retired ☐Student ☐Unemployed ☐ Disabled

**If over age 18, what is the highest grade in school you completed?** ☐Elementary ☐6th ☐7th ☐8th ☐9th ☐10th ☐11th ☐12th
☐GED ☐Attended College ☐ Associate's Degree ☐Bachelor's Degree ☐Master's Degree

## 5 BILLING AND COLLECTION POLICY

Payments of copays, deductibles and any other amount not covered by insurance is expected at the time of service. Any amount not received at your appointment will be billed on your monthly statement. All statements are due in full upon receipt unless prior financial arrangements have been made. Unpaid balances will be subject to our collection process, which may include assignment to an outside collection agency and possible discharge from the practice.

We will submit a claim to all contracted primary and secondary insurance companies with the exception of motor vehicle claims and out-of-state worker's compensation claims. It is your responsibility to supply us with a current copy of your insurance card(s) at each appointment. We do offer a sliding fee discount based on your income and family size. Please ask our front desk staff for an application.

The Billing Office is open Monday through Friday, 8:00 am to 5:00 pm. We accept all major debit/credit cards, checks, cash and Care Credit at our Dental facility. A $29 NSF fee will be applied for all returned checks.

I hereby authorize Siskiyou Community Health Center to provide services to the above named patient and to use and release medical or dental information as required for treatment, payment and health care or dental operations. I also assign Siskiyou Community Health Center payments to which I'm entitled for medical, surgical, behavioral health and dental expenses. I have read and understand the above policy regarding my financial responsibility for all services provided whether covered by insurance or not.

_____ _____
**Patient or Patient Representative Signature** **Date**

## 6 NO SHOW POLICY

An appointment that is not kept, not canceled 24 hours in advance, or is late is called a "No-Show". If you are unable to be at your appointment, it is your responsibility to call and reschedule or cancel the appointment.

**New Patients–**Failure to confirm or cancel your new patient appointment at least 24 hours prior to the appointment time will result in a "no-show" status. New patients that fail to provide appropriate cancellation notice for two (2) appointments will no longer be eligible to establish care with us for twelve (12) consectutive months.

**Established Patients -** If an established patient "No-Shows" four (4) times, they will be notified that they are no longer eligible to schedule future appointments and will be seen in the clinic on a *same day basis* only.

I have read and understand this "No-Show" policy.

_____ _____
**Patient or Patient Representative Signature** **Date**

Siskiyou Community Health Center

## AUTHORIZATION TO TREAT

Please instruct your child care provider or other family member who regularly cares for a minor child to bring this form with them to our office when you can't personally bring your child (under 15 years of age) to give us specific permission to treat your child. That permission must come from the child's parents or legal guardians. It cannot come from sibling, grandparents, etc.

## EMERGENCY CARE AUTHORIZATION

Name of Child and Date of Birth: **Please note: if completing a medical release for multiple children, please use a separate form for each child.*

Name: _____ Date of Birth _____

**Child Care Provider/Family Member Information**

Name (First and Last): _____

Phone Number: _____ Relationship to Patient: _____

I, the undersigned, have given permission for the above mentioned child care provider or family member to seek medical treatment for my child/children, including immunizations, in my absence on the following dates:

Beginning Date: _____ End Date: _____

**I understand that these services may result in charges billed to my insurance and/or myself.**

**Parent/Guardian Contact Information**

Home Phone: _____ Cell Phone: _____

Address: _____

Insurance Carrier: _____ Policy #: _____

_____ _____

Parent Signature Date Printed Name

_____ _____

Witness Signature Date Printed Name

Siskiyou Community Health Center

# ACKNOWLEDGMENT AND CONSENT

I understand that Siskiyou Community Health Center (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice. It may be in the form of written or electronic records or spoken words and may contain information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment;
- Determine my eligibility for a health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible for paying some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception areas.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

**By signing below, I agree that I have reviewed and understand the information above and that I have received or been offered a copy of the Notice of Privacy Practices.**

By: _____ Date: _____

(Patient Signature)

Print Name: _____ Date of Birth: _____

**(Patient Name)**

By: _____ Date: _____

(Patient Representative Signature)

Print Name: _____

**(Patient Representative Name)**

Description of Representative's Authority: _____

# Siskiyou Community Health Center

**GRANTS PASS MEDICAL**
1701 NW Hawthorne Avenue
Grants Pass, OR 97526
(541) 471-3455

**CAVE JUNCTION MEDICAL**
25647 Redwood Highway
Cave Junction, OR 97523
(541) 592-4111

## PEDIATRIC HEALTH HISTORY

*This form must be completed in full, including all dates.*

Patient Name: *(Please print)* _____ Date of Birth: _____

Name of Person Completing Form: _____ Relationship to Child: _____

Primary Care Provider: _____ Today's Date: _____

### MEDICAL HISTORY

| LIST MEDICAL CONDITION(S) | CURRENT? Y/N | DATE DIAGNOSED | PROVIDER SEEN | OFFICE USE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

### ALLERGIES

☐ *No Allergies*

| NAME | REACTION | NAME | REACTION |
|---|---|---|---|
| 1. | | 3. | |
| 2. | | 4. | |

### MEDICATION(S) *(Including over the counter, herbal supplements and vitamins)*

| NAME OF MEDICATION | CURRENT? Y/N | PRESCRIBED BY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**SISKIYOU COMMUNITY HEALTH CENTER**
**PEDIATRIC HEALTH HISTORY** (Page 2 of 3)
*This form must be completed in full, including all dates.*

Patient Name: *(Please print)* _____ Date of Birth: _____

## SURGICAL HISTORY *(Please include year of surgery)*

| SURGICAL PROCEDURE | DATE | PHYSICIAN |
|---|---|---|
| | | |
| | | |
| | | |

## IMMUNIZATION HISTORY *(OR attach copy of child's immunization records)*

| VACCINE | LOCATION | DATE |
|---|---|---|
| **DTaP** (Diphtheria, Pertussis, Tetanus) | | |
| **Flu** (Influenza) | | |
| **HepA** (Hepatitis A) | | |
| **HepB** (Hepatitis B) | | |
| **Hib** (Haemophilus Influenza) | | |
| **HPV** (Human Papillomavirus) | | |
| **IPV** (Polio) | | |
| **Meningococcal** (Meningitis) | | |
| **MMR** (Measles, Mumps, Rubella) | | |
| **PCV** (Pneumococcal) | | |
| **RV** (Rotavirus) | | |
| **TdaP** (Diphtheria, Pertussis, Tetanus) | | |
| **Varicella** (Chickenpox) | | |
| **Other:** _____ | | |

## FAMILY HEALTH HISTORY *Have any of your relatives had any of the following?*

| DIAGNOSIS | CHECK ALL THAT APPLY | RELATIONSHIP | LIVING? |
|---|---|---|---|
| ADD / ADHD | | | |
| Alcoholism | | | |
| Allergies | | | |
| Alzheimer's Disease | | | |
| Arthritis | | | |
| Asthma | | | |
| Bipolar Disorder | | | |
| Birth Defects Type: _____ | | | |
| Blood Disease | | | |
| Cancer Type: _____ | | | |
| CVA (Stroke) | | | |
| Depression | | | |
| Developmental Delay | | | |
| Diabetes | | | |
| Eczema | | | |

| DIAGNOSIS | CHECK ALL THAT APPLY | RELATIONSHIP | LIVING? |
|---|---|---|---|
| Heart Disease | | | |
| High Cholesterol | | | |
| High Blood Pressure | | | |
| Learning Disability | | | |
| Lung Disease | | | |
| Mental Illness | | | |
| Migraines | | | |
| Obesity | | | |
| Osteoporosis | | | |
| Renal Disease | | | |
| Seizure Disorder | | | |
| Thyroid Disease | | | |
| Other: | | | |
| Other: | | | |
| Other: | | | |

**SISKIYOU COMMUNITY HEALTH CENTER**
**PEDIATRIC HEALTH HISTORY** (Page 3 of 3)
*This form must be completed in full, including all dates.*

Patient Name: *(Please print)* _____ Date of Birth: _____

## PREGNANCY / BIRTH HISTORY

Type of Delivery: ☐ Vaginal ☐ C-Section Reason for C-Section: _____

Gestational Age (Weeks): _____ Birth Weight: _____

Pregnancy / Delivery Complications? ☐ Yes ☐ No If yes, what complications? _____

Did your child pass their newborn hearing test? ☐ Yes ☐ No

Breastfed? ☐ Yes ☐ No If yes, for how long? _____

Bottle-fed? ☐ Yes ☐ No If yes, what formula type? _____

Has your child had jaundice? ☐ Yes ☐ No If yes, what kind of treatment did they receive? _____

Is your child enrolled in WIC? ☐ Yes ☐ No

## SOCIAL HISTORY

Primary Residence: (*With whom does your child live most of the time?*) _____

Secondary Residence: (*With whom does your child live part-time, if applicable?*) _____

Parents' Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Language: _____ Language(s) Spoken at Home: _____

## EDUCATION

School Name: _____ Grade Level: _____

Any Learning Disabilities? ☐ Yes ☐ No If yes, what disabilities? _____

Any Special Needs in School? ☐ Yes ☐ No If yes, what special needs? _____

## ACTIVITIES

Exercise / Sports? ☐ Yes ☐ No If yes, what type? _____ Hours per week? _____

TV / Computer Games? ☐ Yes ☐ No If yes, how many hours per day? _____

Does child have a TV in their bedroom? ☐ Yes ☐ No

Does child have a computer in their bedroom? ☐ Yes ☐ No

## HOME ENVIRONMENT / SAFETY

Dental Provider: _____ Last Exam: _____

☐ SCHC Provider ☐ Other ☐ None

Home Heating Type: _____ ☐ None (*No heat source*)

Are there any smokers in the child's home? ☐ None ☐ Inside ☐ Outside Only

Are there smoke detectors in the home? ☐ Yes ☐ No

Does the child use a bike / skating helmet? ☐ Yes ☐ No

What type of car restraint is used? ☐ Rear-facing Car Seat ☐ Front-facing Car Seat ☐ Booster
☐ Seatbelt ☐ None

Siskiyou Community Health Center

# AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Healthcare Provider to ***Release*** Information:

| | |
|---|---|
| **Name** | |
| **Mailing Address** | |
| **Phone** | **Fax** |

Person/Agency to ***Receive*** Information: ☐ **Patient/Self**

☐ **Name**
Siskiyou Community Health Center (SCHC)
1701 NW Hawthorne Ave, Grants Pass OR 97526
PH: 541-471-3455 FAX: 541-471-1439

☐ **Name**
Siskiyou Community Health Center (SCHC)
PO Box 1850, Cave Junction OR 97523
PH: 541-592-4111 FAX: 541-592-3916

**PURPOSE OF THE DISCLOSURE** _____ Transfer of Care _____ Coordination of Care _____ Other _____

**DATES REQUESTED** _____ **ALL** Dates of Service **OR** Date Range: From _____ To _____

**INFORMATION REQUESTED** (**Must initial each item requested**):

_____ Initial here to include **ALL** types of records indicated below **OR** initial the specific records requested

| | | |
|---|---|---|
| _____ Chart Notes | _____ Specialist Consults | _____ Immunization Records |
| _____ Lab Results | _____ Hospital Records | _____ Billing Statements |
| _____ Radiology and Imaging Reports | _____ Physical Therapy Notes | |
| _____ EKG Reports | _____ Other _____ | |

**SPECIFIC CONSENT** (**By initialing the space(s) below, I am specifically authorizing the release of the specified confidential information**):

| | |
|---|---|
| _____ Records regarding mental illness or developmental disability* | _____ Communicable Disease |
| _____ Medical Records relating to alcohol and/or drug abuse | _____ Venereal Disease |
| _____ HIV Test Results | _____ Child Abuse and Neglect |
| _____ Genetic Testing information and results | _____ Sexual Assault |

**EFFECTIVE DATE OF AUTHORIZATION**

_____ Until the purpose is fulfilled

_____ Other _____

I understand that I may revoke this Authorization in writing at any time by notifying the Medical Records Department. I understand that once my health information is disclosed to the recipient, SCHC cannot guarantee that the recipient will not re-disclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws. I understand that I may refuse to sign this Authorization, and if I do refuse, my ability to obtain treatment will not be affected.

I have read and understood this authorization and had a chance to ask questions about the disclosure of the health information. I authorize SCHC to use/disclose my health information in the manner described above.

_____ _____

**Signature of Patient or Personal Authorized by Law** **Date**

_____ _____

***Name and Signature of Witness** *(required for release of information about mental illness or Developmental disability)* **Date**

**Staff Initials**_____

# Siskiyou Community Health Center

## What is the Sliding Discount Program (Slide Program)?

The slide program at Siskiyou Community Health Center is a federal program that allows us to offer discounts on our services to patients who may not have the ability to pay full fees.

*Eligibility is based on your household size and income.*

## Who can apply for the Slide Program?

The slide program is *available to all of our patients*, even those who have insurance including Medicare, Oregon Health Plan and/or private insurance. Applying for our Slide Program has no impact on your current insurance coverage.

## Who is included in the household?

The household includes yourself, spouse and any dependents under 19 years old that live with you. If you have a dependent that is a full time student under the age of 23 you can include them in your household if you claim them on your tax return. You will be asked to submit the most recent tax return as proof. Any other adults in the household, even if they are related, are not included.

## What does the Slide Program cover?

Our slide discounts apply to all services at Siskiyou Community Health Center, including in-office procedures, dental care, pharmacy, and in-house labs.

## If I already have insurance, why would I need the Slide Program?

While your insurance may cover many of the services you receive, the slide program may be able to assist on the balance due after insurance pays, such as copays, coinsurance or deductible amounts. It may also help reduce the cost of services your insurance may not cover such as labs, pharmacy or dental care.

## How do I apply?

You will need to complete a one page application and submit proof of income for every adult listed in the household. If you do not have proof with you today, please talk to the Registration Staff regarding your options.

Once your application is approved it is valid until March 31st. A new application and proof of income will be required on or after April 1st each year to continue to be considered for the slide program.

## What do I need to bring as proof of income?

- **Currently Employed?**
  - A copy of your most current month's worth of pay stubs. If you are paid monthly, you will need to bring 2 month's worth.

- **Self Employed?**
  - A copy of your most recent tax return including the signature page. If you do not file taxes, you will need to bring a financial summary for the current calendar year.

- **Unemployed?**
  - If you are receiving unemployment, you will need to submit documentation that indicates your weekly benefit amount.

- **Social Security Disability or Social Security Retirement Letter** – the most current award letter received. An SSA-1099 will not be accepted.

- **Worker's Compensation Award Letter**

- **Child or Alimony Support** – a copy of the court order showing the monthly amount received.

- **No Income?**
  - If an adult in the household does not work or is not receiving any income, a *Proof of No Income* form will need to be completed.

*Note: Bank Statements will not be accepted unless requested by management.*