Crossroad Health Center Grant Data Collection Form

Year __2017____

Patient Name/Guardian _____

Crossroad Health Center receives Grant Funds to offset some of our costs and also provide care to those in need. Please help us meet our reporting requirements by completing this form.

1. In the box on the left, please circle the number of family members in your household.
2. In the same row, please circle the corresponding income of all family members who support your family household.

2017

Family Size	Family Income (1) 100% and Below	Family Income (2) 101-150%	Family Income (3) 151-200%	Family Income (4) >200%
1	less than 12,060	12,061 - 18,090	18,091 - 24,120	greater than 24,120
2	less than 16,240	16,241 - 24,360	24,361 - 32,480	greater than 32,480
3	less than 20,420	20,421 - 30,630	30,631 - 40,840	greater than 40,840
4	less than 24,600	24,601 - 36,900	36,901 - 49,200	greater than 49,200
5	less than 28,780	28,781- 43,170	43,171 - 57,560	greater than 57,560
6	less than 32,960	32,961 - 49,440	49,441 - 65,920	greater than 65,920
7	less than 37,140	37,141 - 55,710	55,711 - 74,280	greater than 74,280
8	less than 41,320	41,321 - 61,980	61,981 - 82,640	greater than 82,640

Signature_____ Date_____

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Last Review _____ *Intials* _____