



n o r t h e r n c a l i f o r n i a  
**Center for Well-Being**

## **Sliding Scale/Scholarship Eligibility Form**

How many people live in your household (including you)? \_\_\_\_\_

What is the combined monthly gross income of everyone in your household? \$ \_\_\_\_\_

Do you have any health insurance? \_\_\_\_yes \_\_\_\_no

If, yes, name of health insurance \_\_\_\_\_

By signing this form, I affirm that the above information is true and accurate, to the best of my knowledge.

\_\_\_\_\_  
Your Name (sign)

\_\_\_\_\_  
Today's Date

**Please return to the Center for Well-Being with proof of income (i.e. bank statement or pay stub).**

Thank you for completing this form. If you have any questions please call us at 575-6043.