

# SLIDING FEE APPLICATION

Date \_\_\_\_\_ Please allow a two (2) week processing period. Medical Record # \_\_\_\_\_

Name \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ Apt or PoBox \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail address \_\_\_\_\_

Provide a copy of current utility bill \_\_\_\_\_

**FAMILY MEMBERS – Members listed must live in your household.**

Member name	Date of Birth	Social Security #	Employer/Occupation	Relationship
				self

**Sources of Income:**

**Failure to report all income may result in cancellation of approved sliding-fee applied to the household.**

Circle all that apply.

Employment: yes no	Social Security: yes no	SSI: yes no	SSD: yes no
Child Support: yes no	Alimony: yes no	Workers Comp: yes no	
Unemployment: yes no	VA Benefits: yes no	Self-employment: yes no	
Fip/Welfare: yes no	Rental Property: yes no	Cash wages: yes no	

How often are you paid: Weekly \_\_\_\_ Bi-weekly \_\_\_\_ Semi-monthly \_\_\_\_ Monthly \_\_\_\_  
 OTHER \_\_\_\_\_ Please explain \_\_\_\_\_

**Acceptable forms of income verification:** All types of income in the household must be reported.

- Current Federal Income Tax Form (**preferred**)
- Current bank statement showing direct deposits for : SS, SSI, SSD, Fip, Child Support,
- Pension payments, Veteran’s Benefits (bank statements are good only for a fixed income).
- Pay stubs for the last month.
- Court order for alimony or child support **or** printout for child support payments.
- Employer statement for cash wages (must include employer name, address & phone number)
- An award letter.
- Printout from office issuing payments (SS, SSI, SSD, unemployment, VA, etc.)

**Patient Signature** \_\_\_\_\_

I attest that the information above is the total income for my household. We are required to verify all income for certain grants and/or services provided by our clinic. I certify that the above information is true, I have read the information on this application and understand that I must meet the above qualifications to receive assistance through the Sliding-Fee-Scale program. **Patient initials** \_\_\_\_\_