SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name:_____ Date of Request:_____
Last First Middle Date ofAppointment: _____

Address: _____

_____
City State Zip Code

Phone Number: (cell)_____ (home)_____

Number of household members living at the above address_____

Family/Household members: The number of persons living in the household, who cohabit, mutually contribute to household expenses and assert that they are a household unit. It is recognized that other persons may reside at the common residence and not be considered as part of the household unit.

(Any person, including yourself, living in household must be listed below):

Name Date of Birth

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

HOUSEHOLD INCOME (List ALL household income for all adult household members):

	Total for 12 months
Gross Wages, Salaries, Tips	$
Social Security	$
Disability	$
Farm/Self-Employment Net Earnings	$
Unemployment	$
Public Assistance (exclude food stamps)	$
Workers' Compensation	$
Alimony	$

Child Support	$
Military	$
VA Benefits	$
Pensions/Annuities	$
Dividend or Interest Income	$
Rental Income	$
Total	$

PROOF OF INCOME IS REQUIRED FOR EACH ADULT MEMBER OF HOUSEHOLD.

Examples of acceptable proof of income are:

- W-2 Form or most current pay stubs for the last month of employment
- Current tax return
- Unemployment, Social security, Disability, Workers' Compensation award letter
- Child support and/or alimony award letter
- Pension or retirement income information
- Letter from employer establishing income
- Letter from person/persons supplying support showing amount and frequency of support

Does patient currently have any medical insurance? Yes_____No_____
If yes, please complete the following information: (medical)
Name and Address of Insurance: _____
Policy Number: _____
Policy Holder's Name:_____Date of Birth:_____

Does patient currently have any dental insurance? Yes_____No_____
If yes, please complete the following information: (dental)
Name and Address of Insurance: _____
Policy Number: _____
Policy Holder's Name:_____Date of Birth:_____

Occupation of Patient: _____

Employer Name:_____

Employer Address: _____

If you had a change in financial circumstance since your last application, please provide documentation of current income or financial status and write a note explaining how it has changed.

_____
_____
_____

I affirm that the above information is true and correct.

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

For Office Use Only

This document was received on_____By _____

Rate approved per table_____Reapply by _____