PATIENT APPLICATION FOR SLIDING FEE DISCOUNT

Sliding Fee Discount Program Application
All information is confidential.

Patient Information:

- Patient Name:_____
- Date of Birth:_____
- Phone Number: _____
- Address:_____

Household Information:

- Number of people in household:_____
- List household members and relationship:_____

Income Information:

Please provide total gross household income (before taxes):
Income Source:
Wages/Salary:
Self-Employment:
Unemployment:
Social Security/Disability:
Other Income (explain):
Monthly Amount:
Annual Amount:

Total Household Monthly Income: $._____
Total Household Annual Income: $_____
Need Proof of Income (check one):

- • Pay stubs (last 2 months)_____
- • Most recent tax return_____
- • Benefits award letter
- • No documentation available - providing written attestation
- Reason:

Attestation:
I _____,certify that the information provided is true and accurate to the best of my knowledge. I understand that providing false information may result in loss of sliding fee eligibility.

Signature:_____
Date:_____

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