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PATIENT APPLICATION FOR SLIDING SCALE FEE

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: \$ _____

Documents: Need Proof of Income (check one):

- Pay stubs (last 2 months) _____
- Most recent tax return _____
- Benefits award letter _____

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: _____

Please scan and email this application and the supporting documents to: spierreloUIS@iemtherapy.com. You will receive a response after 10 days after you have submitted your documents.