



SLIDING FEE SCALE APPLICATION

PERSONAL INFORMATION

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

ADDRESS – CITY, STATE & ZIP _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

HOUSEHOLD INFORMATION

NAME OF SPOUSE _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

LIST DEPENDENTS CLAIMED ON YOUR TAX RETURN

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP
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PROOF OF INCOME

You must bring proof on income. Most recent tax return Form 4506-T

- I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge.
- ***I understand a nominal fee of \$30.00 will be requested at the time of each medical office visit, a \$35.00 nominal fee will be requested at the time of each dental office visit, and a \$10.00 nominal fee for each behavioral health office visit, and that I will be responsible for any remaining balance.***
- Sliding fee adjustments will go back 60 days from the date the application is approved.

APPLICANT'S SIGNATURE _____ DATE _____

Eligibility Information – For Office Use Only Annual Gross Income \$ _____ # of Dependents _____

_____ Application Approved Nominal Fee Only 20% Payment 40% Payment 60% Payment 80% Payment

_____ Application Denied - RESPONSIBLE FOR 100% OF BILL

PROCESSED BY _____ DATE _____