



**ANNUAL SLIDING FEE APPLICATION**

I OPT OUT TO TAKE SLIDING FEE DISCOUNT & WILL BE RESPONSIBLE FOR THE FULL FEES

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Responsible Party: \_\_\_\_\_ Phone: \_\_\_\_\_

**Household Members: (including everyone living at home)**

Name	Relationship	DOB
_____	_____	_____
_____	_____	_____

**Do you or anyone living with you receive money from job training, work, unemployment, disability, child support, social security, public assistance, rentals, retirement, pension or other?**

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please present verification of income of all that apply

Name (Currently Working)	Source of Payment (Check or Cash)	Source of Verification (Name of Employer)	Monthly
_____	_____	_____	_____
_____	_____	_____	_____

Total Annual Income \$ \_\_\_\_\_ Total in Household \_\_\_\_\_

Are you or anyone in household covered by any health insurance? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If Yes Name of Insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

**Complete the information below ONLY if you have no other way to document your income. All of the boxes below must be checked and all questions answered. Failure to complete this form may result in denial of your sliding fee scale application.**

- I get paid in cash.
- I do not get pay checks.
- I do not get pay stubs.
- I cannot get a letter from my employer. Explain why: \_\_\_\_\_

My cash income is \$ \_\_\_\_\_ How often (weekly, monthly etc.) \_\_\_\_\_  
 Current Employer: \_\_\_\_\_ Family Size \_\_\_\_\_

Applicants/Recipients must read the following and sign below

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for sliding fee scale application. I understand that program officials may verify information on this form.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**Facilitated Enrollers must read the following and sign below**

I certify that I asked the applicant/recipient about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me. I did not modify the information in any way.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of application \_\_\_\_\_ Date of expiration \_\_\_\_\_

Category of Eligibility: Minimal Fee 100% Discount 80% Discount 60% Discount 40% Discount 20% Discount Full Fee  
 Dental Minimal Fee 100% Discount 80% Discount 60% Discount 40% Discount 20% Discount Full Fee

I certify under the penalty of perjury that the statement in regard to income are true and correct to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Interviewer/Staff \_\_\_\_\_ Date \_\_\_\_\_