SLIDING FEE DISCOUNT APPLICATION

*** PATIENT NAME:** _____

*** PATIENT DATE OF BIRTH:** _____

***How many people are dependent on your family income?** _____

***Names of people who you can claim as a dependent:** _____

_____

HOUSEHOLD INCOME MUST INCLUDE:	ANNUAL GROSS HOUSEHOLD INCOME (please check one)
SALARY, WAGES, TIPS, BUSINESS PROFITS, ALIMONY, CHILD SUPPORT, SIGNIFICANT OTHER, RELATIVE, FRIENDS, RETIREMENT FUND/ SAVINGS, PENSIONS, SOCIAL SECURITY, SSDI, PUBLIC ASSIST. WELFARE, VETERAN'S ADMIN. UNEMPLOYMENT COMP., OR OTHER INCOME	____$0 - $10,000 ____$10,000 - $20,000 ____$20,000 - $30,000 ____$30,000 - $40,000 ____$40,000 - $50,000 ____$50,000 - $60,000 ____$60,000 - $70,000 ____$70,000 or above

***What is your Family's Total GROSS Income? $_____Monthly or $_____Yearly**

____I WISH TO DECLINE AT THIS TIME:

SIGNATURE_____DATE_____

PROOF MUST BE PROVIDED *NOTE: Valid proof may be current wage stubs, tax return, or unemployment notice. We can apply your discount up to 120 days back from the date your proof is received.*

I have read the above, and declare the information furnished by me to be true and complete to the best of my knowledge. I will notify Health West of any changes in my income, resources or family size. I also understand that this information will be treated in a confidential manner in accordance with State and Federal Law.

SIGNATURE_____DATE _____

_____DATE_____

Verified By (Staff member)

Applicant is eligible for _____% discount. Proof has been provided? Y N
This application will expire on _____