Sliding Scale Fee Schedule Application

We use this form to decide your discount based on your income.

Patient Name:	Parent or Legal Guardian Name:
Phone Number:	Home Address:
Total # of People Living in Your Home:	

How much money do you and the people living in your home make at your job(s)?

Name	Total Amount	Frequency (circle one)	Name of Employer
You	$	Bi-Weekly Monthly Yearly	
Spouse/Partner	$	Bi-Weekly Monthly Yearly	
Other (grandparent, extended family, etc.)	$	Bi-Weekly Monthly Yearly	

If anyone in your home receives the benefits listed below, how much money do they get each month?
Write the total monthly amount.

Other Income	Unemployment Benefits	SNAP/Bridge Card/WIC	Social Security Benefits	Retirement Pension	Child support	Other
You	$	$	$	$	$	$
Spouse/Partner	$	$	$	$	$	$
Other (grandparent, extended family, etc.)	$	$	$	$	$	$
Children		$				$
Total						

Before approving the application, we must receive at least one document showing proof of income for everyone receiving income in your household. *Examples of acceptable documents include: yearly income tax return, a copy of your W-2 or 1099, three (3) paystubs, a copy of your social security check or social security statement. We may consider other forms of proof of income; please check with office staff first.*

I certify that the information I have provided is true and correct to the best of my knowledge. I understand that if my income changes, I will tell the clinic. I understand that I will be asked to re-apply every year. If I do not accurately provide my income or update it on time, I may lose my discount or be removed from the clinic.

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Patient or Parent/Legal Guardian Signature Date