

## FAMILIES FIRST HEALTH & DENTAL CENTER SLIDING SCALE APPLICATION

You may be eligible for a **discount** on the fees charged for services and supplies you receive here. We receive state, federal and private funds so eligible individuals can receive our services at a reduced cost. The discount is based on your household income. If you wish to apply for a discount, you will need to answer **all** of the questions below. **To complete your application you MUST provide your most recent IRS tax return.** If you have not filed then two current consecutive paycheck stubs OR unemployment check stub may be considered. **If married, you must provide this for you and your spouse.**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

List all people currently living with you on a full time basis (put additional people on the back)

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Please indicate the amount and source of your household income:

\$ _____ Wages	\$ _____ Welfare Payments	\$ _____ Unemployment
\$ _____ SSI	\$ _____ Child Support	\$ _____ Other
\$ _____ Retirement	\$ _____ Alimony	\$ _____ Other
\$ _____ Self Employment	\$ _____ Disability	\$ _____ Other

Your Total Income: \$ \_\_\_\_\_  Weekly  Every two weeks  Monthly  Other (please explain)

Spouse's Total Income: \$ \_\_\_\_\_  Weekly  Every two weeks  Monthly  Other (please explain)

I understand that I am financially responsible for any balance not covered by the sliding scale. A copy of this signature is valid as the original. The information I have provided is accurate and complete. I understand that income and demographic information may be confirmed and/or shared to receive State, Federal, and Private grants. I have seen a copy of the Patient Bill of Rights and am aware of its contents.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_

### FOR OFFICE USE ONLY

**Approved Date:** \_\_\_\_\_  50%  75%  Self Pay

**Usual Medical Co-pay Amount:**  \$10/15  \$15/20  Full payment

**Dental payments:** 75%, 50%, or 0% is taken off of regular dental fees, depending upon slide qualification.

Based on POI of \$ \_\_\_\_\_  weekly  bi-weekly  monthly  annually

**Review in:**  3 months  1 year Expires: \_\_\_\_\_ Staff initials: \_\_\_\_\_