Sliding Scale Fee Application

Instructions for Sliding Fee Scale Qualifications

1) “Sliding Fee Scale Qualification form”: please fill out this form if you are able to provide a check stub, a W2 form, or a bank statement that shows the monthly income of the individuals in your household. If you are employed, on disability, or receive unemployment payments you may use this form. If you do not have a check stub, W2, or bank statement for one individual in your household, you may substitute the form titled “Employment and Wage Verification Form.”

2) “Employment and Wage Verification Form”: if you do not have access to one of the documents listed above, but are employed, please fill out the top portion of this form and have your employer complete the bottom portion, then bring it to when you come during eligibility hours.

3) “Income Assistance Verification Form”: if you do not have a regular source of income, but receive assistance from a government or community organization, please use this form. The form must be completed by someone who is not related to you and who can confirm that you require financial assistance.

Patient Information			**Todays date** ____/_____/____
First Name	Middle Initial	Last Name	
Home Address:	City	State	Zip Code
Mailing Address	City	State	Zip Code

Sliding Scale Fee Application

Home phone Number		Cell Phone Number
D.OB	SS#	Do You have Insurance
Marital Status: Single Married Divorced Widowed Separated		

Are you currently employed? __ Yes __ No

Do you work seasonally only? __Yes __ No

How much money do you and all who live in your household bring in per week $ _____ Month $_____ Year $_____ If you are not working, how are you meeting your monthly expenses? Savings __ Borrowing__ Other__

Do you have Medicaid? __ Yes __ No Did you apply? __Yes __No

Were you denied? __ Yes __ No Do you have Medicare? __ Yes __ No Are you eligible to apply? __ Yes __ No

$_____Unemployment __

$_____Social Security __

$_____ Pension/Retirement __

$_____ Rental Income/Dividends __

$_____ Interest __

$_____ Spousal Support __

$_____ Child Support __

$ _____ Foster Care __

$ _____ Public Assistance (ATAP) __

$ _____ Permanent Fund __

$ _____ Longevity Bonus __

Sliding Scale Fee Application

$ _____ Self-Employed (net amount) __

$ _____ Worker's Comp Benefits __

$ _____ Disability Benefits __

$ _____ Other __

$ _____ Total Monthly/Annual Household Income __

List ALL those living in your household receive: (Amount per year Salary or wages)

Household Member	Relationship	D.O.B/Gender	Annual Income	Employer
	Self			

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I

Sliding Scale Fee Application

further agree to inform [health center name] if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of [health center name]. I hereby acknowledge that I read the foregoing disclosure and understand it.

Name (Print): _____

Date: _____

Signature: _____

EMPLOYMENT AND WAGE VERIFICATION FORM

I, _____, authorize my employer, _____, to release information regarding my income to Dr. K's Family medicine

_____

Signature of Patient Date

_____

Printed Name of Patient

_____

Patient Phone Number

Beginning date of employment: _____

Date of first pay: _____

Hourly wage: _____ Number of hours employee works weekly: _____

How often paid? (Circle one) Weekly Bi-weekly Monthly Other: _____

Do you expect any changes in rate of pay or hours worked? Yes No

If Yes, explain: _____

Sliding Scale Fee Application

Does your employee receive bonuses? Yes No
If Yes, how often are they received: (Circle one) Yearly Every 6 months Other:
_____

Does your employee have health insurance? Yes No If Yes, name of company:
_____

Is employee on paid leave of absence? Yes No

Employer's Name and Title (Printed)
_____ _____

_____ _____
Employer's Signature Date

_____
Employer's Name and Phone number