

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 you must provide proof of all income listed below. 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:

\$ _____ Gross Wages (Two most recent weeks) \$ _____ Unemployment (One check stub or determination letter)

\$ _____ SSI \$ _____ Child Support \$ _____ Welfare Payments

\$ _____ 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: _____ 75% 50% 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: _____