FAMILIES FIRST HEALTH & DENTAL CENTER SLIDING SCALE APPLICATION
FOR INSURED AND UNINSURED PATIENTS (This is *not* health insurance!)

You may be eligible for a **discount** on the fees, insurance copays and/or deductibles charged for services and supplies you receive here, based on your household income. If you wish to apply for a discount, you will need to answer **all** of the questions below and **provide proof of all income**. We accept your most recent IRS tax return, two pay stubs, and proof of other income listed below. If married, you must provide this for yourself and your spouse. **If proof is not attached, your application will be returned.**

Name: _____ DOB: _____

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

Name	Age	Relationship

Employer: _____ Employer Phone: _____ Supervisor: _____

Please indicate the amount and source of your household income:

$ _____Gross wages (Most recent 2 wks) $_____Unemployment (One check stub or determination letter)

$ _____ SSI $ _____Child support $ _____ Welfare payments

$_____ Retirement $ _____Alimony $ _____ Tax Return (AGI)

$_____ 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 as valid as the original. The information I have provided is accurate and complete. I understand that Families First may confirm and/or share income and demographic information in order to receive the state, federal and private funds that allow it to offer services at a reduced cost. I have seen a copy of the Patient Bill of Rights and am aware of its contents.

Signature _____ Date _____

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Approved Date: _____	❒ Category 1	❒ Category 2	❒ Category 3	❒ Category 4	❒ Full Pay
Usual Medical Fee:	❒ $30	❒ 40%	❒ 60%	❒ 80%	❒ Full Pay
Dental Payments:	❒ $40+	❒ 50-60%	❒ 65-75%	❒ 80-90%	❒ Full Pay

Based on POI of $_____ ❒ monthly ❒ annually ❒ refused

Review in: ❒ **6 months** ❒ **1 year** **Expires:**_____ **Staff initials:** _____

❒ **Self-Declaration** **Expires:** _____

Revised 5/17/2018