Sliding Scale Application

|  |  |  |
| --- | --- | --- |
| First Name: | Last Name | DOB |
| Address: | City: | State: |
| Phone number: | Work number: | Text: Y/N |
| Marital Status: Single In a Relationship Married Separated Divorced Widow | Insurance Type: | CoPay: |

Household Size

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Date of Birth |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

Household Income

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Employer | Amount | Frequency |
| 1.Self |  |  | Weekly Bi-Weekly Monthly |
| 2.Spouse |  |  |  |
| 3.Child |  |  |  |
| 4.Additional Income |  |  |  |

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 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.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_