☐ **Patient declines to apply for the Sliding Fee Scale Discount**

La Red Health Center, Inc.

Sliding Fee Scale Application

Valid from March 1, 2019 through February 29, 2020

This application must be completed in its entirety in order to be processed. All questions must be answered.

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: ____/____/____

HOUSEHOLD INFORMATION

Name of Spouse: _____

Date of Birth: ____/____/____ Social Security Number: ____-____-____

List all Dependents:

	Name	Social Security No.	Date of Birth	Relationship
1.	_____	____-____-____	____/____/____	_____
2.	_____	____-____-____	____/____/____	_____
3.	_____	____-____-____	____/____/____	_____
4.	_____	____-____-____	____/____/____	_____
5.	_____	____-____-____	____/____/____	_____

PROOF OF INCOME

You must bring proof of All Household Income:

( ) Most Recent Income Tax Return
( ) Social Security/Disability
( ) Form 4506-T
( ) Last two Pay Stubs

I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge. ***I understand that I am responsible for any applicable charge balances at the time of each service.***

_____ _____

Applicant's Signature Date

ELIGIBILITY INFORMATION – FOR OFFICE USE ONLY

Annual Gross Income $_____

Number of Dependents_____

☐ Application Approved

Sliding Fee Scale (☐A) (☐ B) (☐ C) (☐ D) (☐ E)

☐ Application Denied – RESPONSIBLE FOR 100% OF BILL

_____ Gross Income 1

_____ Gross Income 2

_____ Gross Income 3

_____ **Total Income**

_____ _____

Processed By Date