



**La Red Health Center, Inc.  
Sliding Fee Scale Application**

**Valid from March 1, 2021 through February 28, 2022**

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

Patient declines to apply for the Sliding Fee Scale Discount

**HOUSEHOLD INFORMATION**

Guarantor Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

List all Dependents:

Name	Date of Birth	Relationship	Patient
1. _____	____/____/____	_____	[ ]
2. _____	____/____/____	_____	[ ]
3. _____	____/____/____	_____	[ ]
4. _____	____/____/____	_____	[ ]
5. _____	____/____/____	_____	[ ]

**PROOF OF INCOME**

You must bring proof of ( ) Most Recent Income Tax Return ( ) Bank Statements  
All Household Income: ( ) Social Security/Disability ( ) 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 \_\_\_\_\_

\_\_\_\_\_  
Gross Income 1

Application Approved

\_\_\_\_\_  
Gross Income 2

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

\_\_\_\_\_  
Gross Income 3

Application Denied – RESPONSIBLE FOR 100% OF BILL

\_\_\_\_\_  
Total Income

\_\_\_\_\_  
Processed By

\_\_\_\_\_  
Date