



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

**Valid from March 1, 2018 through February 28, 2019**

This application must be completed entirely in order to process. All questions must be answered.

Patient declines to apply for the Sliding Fee Scale Discount

**PERSONAL INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Phone Number: (Home) (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: (Cell) (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**HOUSEHOLD INFORMATION**

Name of Spouse: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 List all Dependents:

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

**PROOF OF INCOME**

You must bring proof of ( ) Most Recent Income Tax Return ( ) Form 4506-T  
 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 \_\_\_\_\_

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