La Red Health Center, Inc.

Sliding Fee Scale Application

Valid from March 1, 2009 through February 28, 2010

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

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: _____

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

List Dependents under the age of 18:

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

PROOF OF INCOME

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

( ) 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 also understand a minimum payment of $30.00 will be requested at the time of each medical office visit.***

_____ _____

Applicant's Signature Date

ELIGIBILITY INFORMATION – FOR OFFICE USE ONLY

Annual Gross Income $_____ Number of Dependents_____

[ ] Application Approved ( ) 20% Payment (A) ( ) 40% Payment (B)

( ) 60% Payment (C) ( ) 80% Payment (D)

[ ] Application Denied – RESPONSIBLE FOR 100% OF BILL

_____ _____

Processed By Date