



SLIDING FEE APPLICATION

	Patient Information	Guarantor Information (if different than pt.)
Patient Name	_____	_____
Relationship to Patient	_____	_____
Date of Birth	_____	_____
Home Phone #	_____	_____
Work Phone #	_____	_____
Cell Phone #	_____	_____
Address	_____	_____
City	_____	_____
State	_____	_____
Zip	_____	_____

Employment Status (check one):

Employed _____ Retired _____ Disabled _____ Unemployed _____ Student _____ Dependent _____
Seasonal _____

Household Information:

Number of IRS Dependents _____
Number of Other Household Members (that are not dependents not including self) _____

Income Information: Please list your monthly income from all sources below.

	Patient (or Guarantor)	Other Household Member's Income	Total Household Income
Employment	_____	_____	_____
Pension	_____	_____	_____
Income	_____	_____	_____
Workers Compensation	_____	_____	_____
Unemployment	_____	_____	_____
Interest / Dividends	_____	_____	_____
Alimony or Support	_____	_____	_____
Rental Property	_____	_____	_____
Other (please specify)	_____	_____	_____
Total Monthly Income	_____	_____	_____

Please attach a copy of the following:

- 1) Prior year's federal income tax return
- 2) Pay stubs for the past 2 months
- 3) Outside Medical Debt



Monthly Expenses Please list your monthly expenses below:

Rent/Mortgage \$ _____
Utilities \$ _____
Food \$ _____
Phone/Pager \$ _____
Auto Loan \$ _____
Auto Insurance \$ _____
Loans \$ _____
Child Support \$ _____
Alimony \$ _____
Credit Cards (min payment) \$ _____
Total Medical Debt \$ _____
Other \$ _____

Total Monthly Income \$ _____
Total Monthly Expenses \$ _____
Amount Available \$ _____ x 12 = Annual _____

Affirmation of Financial Disclosure

Omitting information or providing fraudulent information will be cause for rejection of application.

I, _____ certify that the above information is true and complete. I understand that the information provided on this form may be verified before approval for assistance may be granted.

Signature of Patient or Responsible Party

Date

The patient/guarantor will be notified in writing within 10 days of the decision to approve or deny the application.

Updated:

For Office Use Only	
Recommendation: ___ Full Charity (Fully Indigent) ___ Partial Charity: _____ % ___ Medically Indigent ___ Denied: Reason: _____	Reviewed/Approved by: _____ Date: _____