

### SLIDING SCALE FEE APPLICATION

Patient Information			Today's Date: / /			
First Name:	Middle:	Last:	Other names:			
Home Address:		City:	State:	Zip:		
Mailing Address:		City:	State:	Zip:		
Home Phone #: ( ) -		Home Phone #: ( ) -				
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No			
Marital Status:	Single	In a relationship	Married	Divorced	Separated	Widowed

Household Size		
Name	Date of Birth	Social Security Number
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Household Income			
Name	Amount	Frequency (Circle one)	Employer:
You	\$	Weekly Monthly Yearly	
Spouse	\$	Weekly Monthly Yearly	
Children	\$	Weekly Monthly Yearly	
Other	\$	Weekly Monthly Yearly	
	\$	Weekly Monthly Yearly	
<b>TOTAL</b>	\$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				<b>TOTAL</b>	\$

Sliding Fee Scale:  
 A – 100% Discount  
 B – 80% Discount  
 C – 60% Discount  
 D – 40% Discount  
 E – 0%Discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program. I further agree to inform North End Waterfront Health if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of North End Waterfront Health. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: \_\_\_\_\_

(Print Name): \_\_\_\_\_

Signature: \_\_\_\_\_

**Affidavit**

I \_\_\_\_\_ certify that I am unemployed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date