



MEDICAL/DENTAL/VISION SLIDING FEE SCALE APPLICATION
WE ARE AN EQUAL OPPORTUNITY PROVIDER

Applicant's Name _____ /_____/____ MRN _____
Date of Birth

PLEASE LIST SPOUSE/PARTNER AND DEPENDENTS UNDER 18

Office Use Only

Table with 7 columns: Name (Last, First), Date of Birth, Relationship, Apply SF, Q/A for Ins, MRN. Rows 1-6.

Number of household members: _____ *Additional family members may be added to the back of this form

NOTE: COPIES OF FEDERAL INCOME TAX, PAY STUBS, OR OTHER INFORMATION VERIFYING INCOME IS REQUIRED BEFORE A DISCOUNT IS APPROVED.

IMPORTANT: The following services are a separate discounted charge and are not included in the nominal fee payment:
- Certain labs sent outside of our facility
- Eye glasses
- Contact lenses (no additional discount)
- Dental Cosmetics

ATTESTATION: BY SIGNING BELOW, I ATTEST THAT, AS OF THE DATE OF MY SIGNATURE, THE INCOME SOURCES PROVIDED CONSTITUTE ALL OF MY HOUSEHOLD INCOME, AND THAT THE HOUSEHOLD MEMBERS LISTED ARE ALL SOLELY DEPENDENT ON THAT INCOME, OR THAT THE EXPLANATION PROVIDED TO VERIFY MY INCOME LEVEL IS TRUTHFUL.

Applicant Signature: _____ Date: _____

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Effective date: _____ Expiration date: _____
Total yearly income: \$ _____
Approved by: _____ Initials: _____

Table with 5 columns: Level 1, Level 2, Level 3, Level 4, Level 5. Rows: Nominal fee (100% Disc), 25% pay (75% disc), 50% pay (50% disc), 75% pay (25% disc), No Discount

Income verification: [] Paycheck Stub(s) [] Support Statement [] Federal Income Taxes [] SSI Letter [] SSA Letter
[] Unemployment Letter [] Public Assistance [] Other _____

Notes: _____