# Medical/Dental/Vision Sliding Fee Scale Application

We are an equal opportunity provider.

## Applicant’s Information

- **Name (Last, First):**
- **Date of Birth:** __________
- **MRN:** __________

## Please List Spouse/Partner and Dependents Under 18

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<tr>
<th>Name (Last, First)</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Apply SF</th>
<th>Q/A for Ins:</th>
<th>MRN</th>
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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:** ____________________

### Office Use Only

**Effective date:** __________  **Expiration date:** __________

**Total yearly income:** $________

Approved by: _____________________  **Initials:** __________

**Income verification:**
- ☐ Paycheck Stub(s)
- ☐ Support Statement
- ☐ Federal Income Taxes
- ☐ SSI Letter
- ☐ SSA Letter
- ☐ Unemployment Letter
- ☐ Public Assistance
- ☐ Other __________________________

**Notes:**
______________________________________________________________________________________________________________________________