SOUTHSIDE
Your Community Health Services

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

_____ _____/_____/_____ MRN_____
Applicant's Name Date of Birth

PLEASE LIST SPOUSE/PARTNER AND DEPENDENTS UNDER 18

	Name (Last, First)	Date of Birth	Relationship	Apply SF (Office Use Only)	Q/A for Ins: (Office Use Only)	MRN (Office Use Only)
1				Y / N	Y / N	
2				Y / N	Y / N	
3				Y / N	Y / N	
4				Y / N	Y / N	
5				Y / N	Y / N	
6				Y / N	Y / N	

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

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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: _____

Level 1	Level 2	Level 3	Level 4	Level 5
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
❑ Unemployement Letter ❑Public Asistance ❑ Other _____

Notes:
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