SMITH FAMILY HEALTHCARE

SLIDING FEE SCALE APPLICTATION

Sliding Fee Discount Information

It is the policy of SMITH FAMILY HEALTHCARE to provide essential services regardless of the patient's ability to pay. SFH offers discounts based on family size and annual income.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

NAME:		PHONE:	
STREET:	CITY:	STATE:	ZIP CODE:

Please list all household members including those under the age of 18.

	Name	**Date of Birth**
Self:		
Other:		
Other:		
Other:		

Source	Self	Other	Total
Gross wages, salaries, tips, etc			
Income from business and self-employment			

Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
Total Income			

I Certify that the family size and income information shown above is correct.

Name (Print):_____

Signature:_____ Date:_____

Office Use Only

Patient Name: _____
Approved Discount: _____
Approved by:_____
Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		