SLIDING FEE APPLICATION

For your assistance, we have a sliding fee discount program. In order for us to determine if you qualify, please provide us with the following information.

Parent/Guarantor Name: ______________________ Date of Birth: ______________

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________ Phone: ______________

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Employer: ______________________ Employer Phone: ______________

Employer Address: ____

HOUSEHOLD INCOME: *The income of all household members must be reported and counted.*
Income for minors seeking Family Planning services*: Income is based on the minor's income only.*

How many people are supported by this income? ______________________
Use the number of persons who live in the same household and who share income, food and rent. That number may include you, your spouse, and/or any dependents.

Indicate all source(s) of income for your household. Please check all that apply.

Wages and Salary		Striker Benefits	
Unemployment		Public Assistance	
Self-employment		Child Support	
Social Security / SSI		Veteran's Benefits	
Pension Funds		Alimony	
Workers' Compensation		Other Income (please specify)	

TOTAL ANNUAL GROSS INCOME $ ______ (Gross income is before taxes and deductions)

All sources of income must be documented. Depending on your source of income, at least one of the following documents is required with this application:

1. Two paycheck stubs (most recent for wages)
2. Benefit statement
3. Bank statement (for direct deposit payments)
4. Court orders or other documents

If I have not supplied **proof of income** today, I will do so within **30 days** or be subject to the **full charge** for all services.

I certify that the information I have provided on this application is true and accurate and I acknowledge it is subject to further verification.

______________________ ______________________
Signature of Responsible Party Date