WELLSPACE HEALTH

Sliding Fee Application

Registration & Financial Information

Personal Information: Give us some details about the patient.

MRN: _____
Office Use Only

Patient Information

Last Name: _____ First Name: _____

Middle Initial: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Would you like to see if you qualify for our Sliding Fee Discount Program?

☐ Yes (please move on to the next section)

☐ No (please sign and date below and return this form)*

Sign: **Refusal Date:**

**Please note that if you choose not to complete this application, you will not qualify for any discounts under our Sliding Fee Discount Program and may be responsible for the full cost of your medical or dental care.*

Head of Household

This is usually the person who makes the most money in the home.

Same as patient? ☐ Yes ☐ No

If no, please let us know who the Head of Household is:

Last Name: _____ First Name: _____ Middle Initial:

Relationship to Patient: _____ Date of Birth: _____

Financial & Household Information: Tell us how much money you and your family make and how many people live in your home.

How much money is made from all jobs? (A)

☐ Monthly $ _____ ☐ Every 2 Weeks $ _____

☐ Weekly $ _____ ☐ Twice a Month $ _____

Is anyone in your household self-employed? ☐ Yes ☐ No

If yes, how much money is made every month? $ _____

Other Sources of Money	Monthly Total *in the home*
Child Support/Alimony	$
Unemployment	$
Disability/Workers Comp	$
Interest/Dividends	$
Social Security/SSI *(Add survivors' benefits)*	$
Pensions	$
Rental Income	$
Public Assistance *(Not including food stamps)*	$
Education Assistance	$
TOTAL (B)	**$**

People in the Home *(People who share all money made and bills - children too)*	Relationship to Patient	Date of Birth
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
	TOTAL PEOPLE	

Sign Here: By signing below you are saying that you agree to the statement in the box.

I know that giving false information may disqualify me for discounts. I also know, if disqualified, I will have to pay for the full fee and will not be eligible for the Sliding Fee Program.

I know that just because I apply for a discount does not mean I will get a discount. I also know that if I do not bring in proof of my income, or tell WellSpace Health about any changes to how much money I make or the amount of people in the house, WellSpace Health may immediately take away any discounts.

I know that information on this form will only be shared internally for purposes of the Sliding Fee Program.

Person Responsible for Paying

Sign:_____ **Date of Birth:** _____

Name & Relationship:_____ **Date:** _____

This form does not bind other agencies to honor the given discount and they may ask for more information.

--- OFFICE USE ONLY ---

Take the number reported in (A) and times it by the appropriate amount to get (A*)
Weekly: x 4.33 Every 2 Weeks: x 2.167 Twice a Month: x 2

Household size:	Monthly Income:	Category:	Total Annual Income:
_____	Wages (A*): $ _____ Other (B): $\_\_\_\_\_ **TOTAL:** **$** _____ **(A* + B)**	_____ (A, B, C, D or Self) Fee: $ _____	$ _____

Reviewed By: _____ O&E Referral: _____ Renewal Date: _____

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