Sliding Fee Eligibility Form

Today's Date: _____	
Name:	DOB:
Address:	SS#
City/State/Zip Code:	MRN:
Phone#:	

It is necessary for us to ask personal questions to determine your eligibility for discount on our medical, dental and behavioral health expenses. This information will be kept on file in our center in strict confidence. You must verify your income at least once a year. We need a copy of your yearly income tax return or copy of your W-2 form, at least the last 3 payroll pay stubs, social security benefit letter or other proof of income. Your annual income will be used to calculate the level of payment.

Marital Status (circle one): Single Married Divorced Separated Widow(er)

Living Arrangement (circle one): Own Rent Living w/someone Homeless

Do you have any type of insurance that will cover all or a portion of your medical expenses? (circle one) **Yes** (if yes list below) **No**

Name of insurance company: _____

Household Size: _____

Name	DOB	SS#	Relationship

Household Income

	Amount	Frequency (circle one)	Employer
You		Weekly / Monthly / Yearly	
Spouse		Weekly / Monthly / Yearly	
Children		Weekly / Monthly / Yearly	
Other		Weekly / Monthly / Yearly	

Other Income	You	Spouse	Children	Other	Total Amount
Unemployment					
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Rental Income					
Child Support					
Alimony					
Other (Specify)					

I declare the above information is true and have given the Gerald L Ignace Indian Health Center, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change then I am required to notify the receptionist on my next visit to the clinic.

Signature: _____ **Date: _____**