Sliding Fee Eligibility Form

Today's Date _____

Full Name of Applicant:	DOB:
Full Name of Patient (if different from above):	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 either your yearly income tax return, 1 month of paystubs, social security benefit letter and/or other proof of income from employer. *We do not accept handwritten letters, unless they are from your employer with declaration of monthly payments paid to you from your employer.* Your annual income will be used to calculate the level of discount. The application process may take up to a month to complete. If all documentation is not provided, your application will be denied. You may receive a statement while your application is being processed, once the application is processed and qualified for a discount, you will receive an updated statement.

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	Relationship to applicant	Employed Y/N

Household Income

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

Other Income	You	Spouse	Children	Other	Total Amount
Unemployment					
Social Security					
Public Assistance					
Retirement Pension					
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 if my income should change, I will notify the clinic. I understand that this information will be kept in strict confidence and my application will be kept on file for 12 months from the date of application.

Signature: _____ **Date:** _____