Name: ____Date of Birth: _______________

Address: _______________________________________City, ST, Zip____________________

SLIDING FEE SCALE APPLICATION

The Sliding Fee Scale is based on your ability to pay. If you wish to participate in the Sliding Fee Scale program, it is necessary for us to ask personal questions regarding financial status. This information will be kept on file within our clinic in strict confidence. The most current, appropriate, **TOTAL HOUSEHOLD** income must be furnished to 1st Choice Healthcare, Inc. at the time of your visit. Household income is defined as; ***gross income earned from all persons residing within the home.***

Approved forms of proof of income:

- W-2 Forms or Income Tax Returns
- Social security check/Letter of Award or proof of governmental assistance
- Check stub dated within 30 days of your visit
- Written notice from employer

Household Size: ___ Include all members in your household

Full Name	Date of Birth	Gender	Relationship to patient

If you are applying for the Sliding fee Scale and do not have proof of income with you at the time of your visit, you will be expected to provide us with proof of income by the **next business day,** or you may be billed for the total amount. You will be required to pay a fee based on the sliding fee scale in effect. The minimum payment required from self-pay patients is $20.

By signing below, I certify that the above information is correct and I understand that failure to make full disclosure of total household income is considered an act of fraud and can be punishable by either a fine and/or imprisonment according to federal law. I agree to immediately inform 1st Choice Healthcare, Inc. if any of the reported information changes. I understand that I will be asked to update this information every twelve months. I understand I am fully responsible for my bill if I do not comply with the above requirements.

____ ______________________

Patient/Guardian Signature **Date**

I would like information/assistance on applying for Medicaid or insurance that may be available. Yes ☐ **No** ☐

For Office Use Only:	
Total income:	Number in household:
SFS Level:	Effective date:
Expiration date:	Medicaid information/application:
Insurance information/application:	Verified by:

Updated 08/01/2016