Sliding Fee Scale: Form

Patient Information		**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:
Home Address:		City:	State: Zip:
Mailing Address:		City:	State: Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -	
Date of Birth: / /		Do you have insurance? (circle one) Yes No	

Household Size

Name	**Date of Birth**	**Social Security Number: (optional)**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Please bring yearly income tax return, copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive as proof of family income. Only the family size and annual income will be used to determine your eligibility and calculate your discount.

Household Income

Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
Total	$	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support					
Alimony					
Interest Income					
Other					
				Total	**$**

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Lakeside Health Clinic if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Lakeside Health Clinic. I hereby acknowledge that I read the foregoing disclosure an d understand it.

Name (Print): _____

Signature: _____ Date: _____/_____/_____