Sliding Fee Discount Application

It is the policy of Bridging Health Clinic to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the clinic to determine if you are eligible for a discount.

The discount will apply to all services received at this practice, but not those services or equipment that are purchased from outside, including medications or diagnostic testing. This form must be completed every 12 months and if your financial situation ever changes.

Name: _____
Place of Employment: _____
Address (City, State, Zip): _____
Phone Number: _____
Date of Birth: _____

Please list spouse and dependents under age 18.

Name	Relationship	Date of Birth

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self -employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

Annual Household Income must be verified with copies of tax returns, pay stubs, or other information verifying income will be required before a discount is approved.

I certify that the family size and income information shown above is correct.
Name: _____
Signature: _____
Date: _____

Office Use Only

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year's tax return, three most recent pay stubs or other		

Patient Name: _____
Approved Discount: _____
Approved By: _____
Date Approved: _____