SLIDING FEE APPLICATION & SELF-DECLARATION OF INCOME

☐ **Please check here if you decline to provide income information, please note that you will be ineligible for the sliding fee discount if you do not provide this information.**

To Be Completed by Patient/Guardian for EACH member of the household:				
	Name	**Relationship**	**Date of Birth**	**Annual Income**
1				
2				
3				
4				
5				
6				

Please list all combined gross monthly income received *(i.e. wages, SS, state assistance, alimony, etc.)*:

Wages		Child Support	
Wages		Retirement	
State Assistance		Unemployment	
Alimony		Other	
		Other	
		Total Monthly Income	

Are you currently homeless? ☐ No ☐ Yes

If yes, please describe your current living situation: _____
_____
_____

If you have no income, please explain how you pay your monthly expenses including housing: _____
_____
_____

Acknowledgement

To the best of my knowledge, the information above is true and correct. I understand it is my responsibility to notify Heritage Health of any changes to my income. I also understand that I must re-apply for a sliding fee discount schedule at least once every 12 months, or sooner if my income changes.

Print Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Relationship to Patient: _____

For official office use only:

Homeless Status: ☐ *No* ☐ *Yes; details:* _____

Amount of supported monthly income: _____ *x12 =* _____ *(Annual Income)*

Number of supported people in a household: _____ *Group #:* _____ *CSR Initials:* _____