☐ **Patient declines to apply for the Sliding Fee Scale Discount**

La Red Health Center, Inc.

Sliding Fee Scale Application

Valid from March 1, 2023 through February 29, 2024

This application must be completed in its entirety in order to be processed. All questions must be answered.

HOUSEHOLD INFORMATION

Guarantor Name: _____

Date of Birth: ____/____/____

List all Dependents:

Name	Date of Birth	Relationship	Patient
1._____	____/____/____	_____	[ ]
2._____	____/____/____	_____	[ ]
3._____	____/____/____	_____	[ ]
4._____	____/____/____	_____	[ ]
5._____	____/____/____	_____	[ ]

PROOF OF INCOME

You must bring proof of All Household Income:

( ) Most Recent Income Tax Return
( ) Social Security/Disability
( ) Bank Statements
( ) Last two Pay Stubs

I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge. ***I understand that I am responsible for any applicable charge balances at the time of each service.***

_____ Applicant's Signature

_____ Date

ELIGIBILITY INFORMATION – FOR OFFICE USE ONLY

Annual Gross Income $_____

Number of Dependents_____

☐ Application Approved

Sliding Fee Scale (☐A) (☐ B) (☐ C) (☐ D) (☐ E)

☐ Application Denied – RESPONSIBLE FOR 100% OF BILL

_____ Gross Income 1

_____ Gross Income 2

_____ Gross Income 3

_____ **Total Income**

_____ Processed By

_____ Date