Sliding Fee Application

Patient Information

Name: **Today's Date:**

Date of Birth:

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

Household Income			
Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	**Weekly/Monthly/Yearly**	
Spouse	$	**Weekly/Monthly/Yearly**	
Children	$	**Weekly/Monthly/Yearly**	
Other People Living in Your Household	$	**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					

NOTE: To comply with federal regulations, in order to give you a discount on our medical-dental services, it is necessary for us to ask personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least once a year. Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size (including any other persons living in your house) will be used to calculate your discount. I do hereby swear of affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I understand that any misleading or falsified information and/or omissions may disqualify me from eligibility for the sliding fee program and may subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Arkansas Verdigris Valley Health Centers (AVVHC) if there is a significant change in my income. My signature below indicates that I read and understand the foregoing disclosure

Date:_____ Name(Print):_____

Signature:_____