**Sliding Fee Application**

Patient Name | Date of Birth | Social Security Number

Address-City, State & Zip

Spouse Name | Date of Birth | Social Security Number

Number of people in your family _____

*For each household member:*

| **Name** | **Date of Birth** | **Relationship** | **Gross Income** |
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**You must provide proof of income.**

*Income verification may include: pay stubs, W-2, 1099, most recent tax return, tax transcript, etc.

**Nominal fee of $20 will be requested for each medical visit, a $35 nominal fee will be requested for each dental visit, and the patient will be responsible for any remaining balance.

Signature of patient | Date

**Eligibility Information-For office use only**

Household size | Annual Gross Income

Level of Discount: □ 0% □ 10% □ 30% □ 50% □ 75% □ $100% (Nominal fee only)