Household Assessment – Sliding Fee Scale Program

Patient Name _____ Date of Birth _____

I understand that by filling out the information below, I will be eligible to participate in the Sliding Fee Scale Program subject to income guidelines. I agree to pay the full and entire amount for treatment given to me or to the above named patient as determined by the Sliding Fee Scale Program. I also understand that I will be considered a "full fee" patient after the first visit and for every visit thereafter until proof of income is provided.

Patient/Guarantor Signature _____ Date _____

HOUSEHOLD INFORMATION
Please list all members of your household, including yourself

NAME	RELATIONSHIP	D.O.B.	AGE	ANNUAL INCOME	SEX

****

FOR OFFICE USE ONLY

	YES	NO
IDENTIFICATION / ADDRESS: DRIVER'S LICENSE, EMPLOYMENT I.D., BIRTH CERTIFICATE, S.S. CARD, UTILITY BILL, PHONE, CABLE BILL	☐	☐
INCOME: PRIOR YEAR TAX RETURN, 2 MOST RECENT PAY STUBS, UNEMPLOYMENT STATEMENT, DISABILITY STATEMENT, DOCUMENTATION OF GOVERNMENT ASSISTANCE, CHILD SUPPORT/ALIMONY	☐	☐

VERIFIED BY: _____ **DATE:** _____