Discounted/Sliding Fee Program Attachment A

Name of Head of Household: _____ Phone _____

Place of Employment: _____

Address: _____City _____ State _____ Zip _____

Please list spouse and dependents under age 18

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Income Information

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support assistance from outside the household, and other miscellaneous sources				
Total Income				

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print) _____ Date_____

Signature _____

Office Use Only			
Patient Name	Discount		
Date of Service	Approved by		
Verification Checklist (attach copies)	**Yes**	**No**	
Identification/Address: Driver's license, utility bill, employment ID or other	☐	☐	
Income: Prior year's tax return, three most recent pay stubs or other	☐	☐	
Insurance: Insurance card(s)	☐	☐	

If you have any questions regarding this application, please call our Business Office at 254-803-3561 EXT 2374