



# TouchStone

HEALTH CLINIC

*Where healing begins*

## **Medical - Sliding Fee Discount Application**

It is the policy of TouchStone Health Clinic to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. **Please complete the following information and return to the front desk** to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, and must be completed every 12 months or when your financial situation changes.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

**Please list spouse and dependents under age 18.**

	NAME	DATE OF BIRTH		NAME	DATE OF BIRTH
SELF			DEPENDENT		
SPOUSE			DEPENDENT		
DEPENDENT			DEPENDENT		
DEPENDENT			DEPENDENT		



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## Annual Household Income

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc				
Income from business, self-employment, and dependents				
Unemployment 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 from outside the household, and other miscellaneous sources				
<b>Total Income</b>				

**Note: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.**

I certify that the family size and income information shown above is correct.

Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_



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**Office Use Only**

Patient Name: \_\_\_\_\_

Approved Discount: \_\_\_\_\_

Approved by: \_\_\_\_\_

Date \_\_\_\_\_

Verification Checklist	Yes	No
Identification/address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance cards		