SLIDING FEE SCALE

It is necessary for us to ask personal questions in order to give you a discount on your Medical, Behavioral Health and Dental expenses. This information will be kept on file in our clinic in strict confidence. You must verify your income at least every year. Your yearly income tax return with a copy of your W-2 form, payroll check, or other check you may receive will be sufficient proof. Your annual income will be used to calculate the level of your payment.

PATIENT INFORMATION

Name ___________________________________Date Of Birth ____________________ SS# _________________________

Address _________________________________City, State ______________________________ Zip_________________

HOUSEHOLD INFORMATION

Number of People Living In Your Home: ___________

Please list all people living at your address and their date of birth			
Name	**Date of Birth**	**Name**	**Date of Birth**

Amount of Income	You $	Your Spouse $	Your Children $	Other Persons $
Place of Employment	You	Your Spouse	Your Children	Other Persons

OTHER INCOME SOURCE

Do you receive any income from any of the following sources, and if so, how much?					
Sources	You	Your Spouse	Your Children	Other Persons	TOTAL
Social Security	$	$	$	$	$
Public Assistance	$	$	$	$	$
Black Lung	$	$	$	$	$
Retirement Pension	$	$	$	$	$
Food Stamps	$	$	$	$	$
Rental Income	$	$	$	$	$
Interest Income	$	$	$	$	$
Other (specify)	$	$	$	$	$

I declare the above information is true and have given the Dayspring Health permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if any income should change, that I am required to notify the receptionist on my next visit to the clinic.

Signature: ____ Date: __________________

OFFICE USE ONLY: Income Verified Initials ________ Income Code _________ Start Date ______________