Chase Brexton Health Care
Because everyone's health matters.

Sliding Fee Scale Application Form

Patient Legal Name: _____ Date of Birth:_____

Preferred Name: _____ Phone #: _____

Insurance Status: ___ no insurance ___ commercial insurance/Medicaid/Medicare

Source of Income	You	Household Member 1	Household Member 2	Household Member 3	Subtotal
Job #1	$	$	$	$	$
Job #2	$	$	$	$	$
Job #3	$	$	$	$	$
Social Security/SSI	$	$	$	$	$
Disability	$	$	$	$	$
Retirement/Pension	$	$	$	$	$
Veterans Benefits	$	$	$	$	$
Child Support	$	$	$	$	$
Alimony	$	$	$	$	$
Unemployment	$	$	$	$	$
Other	$	$	$	$	$
				Yearly Income	**$**

You must include proof for each of your types of income, such as a W-2, tax return, check stubs, or official benefits letter. Unfortunately, bills cannot be taken into consideration when applying for a sliding fee.

Household Members (***Write down everyone who lives in your house or apartment. You will need proof of income for each adult. For each child you will need an ID or W-2 showing the child is your dependent.)***		
Name	**Relationship**	**Age**

I promise that the information provided on this form is true to the best of my knowledge. I understand that any false information or **missing sources of income** may **disqualify me** from the sliding fee program.

I agree to inform Chase Brexton if there is a significant change in my income.

Patient Signature: _____ Date: _____

Approved 3/24/17