Sliding Fee Scale Application (SFS)

Patient Name	If patient is a minor, Guarantor Name
Patient Date of Birth	

BELOW, LIST THOSE PEOPLE THAT WERE INCLUDED ON YOUR FEDERAL TAX RETURN:

1. **You will need to provide proof of identity for *ALL* members listed below**
2. **For any member 19 and over you will need to provide proof of income/no income**

Name	Relationship	Social Security #	Date of Birth	Windrose Patient	Income	Insurance
1.				Y N	Y N	Y N
2.				Y N	Y N	Y N
3.				Y N	Y N	Y N
4.				Y N	Y N	Y N
5.				Y N	Y N	Y N
6.				Y N	Y N	Y N
7.				Y N	Y N	Y N

Is anyone listed on this application pregnant? □ Yes □ No
Has patient applied for Medicaid or Insurance in the past 30 days?
Yes_____ /Date_____ No_____

You will have 30 days to provide all of the required information/documentation. If you do not provide *ALL* of the information/documents, the Sliding Fee Scale Application will be *DENIED.* This means that the applicant and all household members will pay in full, until the required information/documents are received and a new Sliding Fee Scale application is completed.

I certify the information shown above is accurate and true. I understand that if I have provided false information, my account will default to the full amount due for services rendered. I also understand that this application is good for 12 months, after which time, I will be asked to update my information.

Applicant's Signature_____
Date_____

FOR OFFICE USE ONLY **Employee Initials**_____

Application date		**Level A until expiration date**_____
Docs still needed		
Docs provided		

INCOME VERIFICATION

Patient Name	DOB

Enter the proof of household income/no income for all family members over 19 years of age who are listed on the application

Applicant Name	Gross Wages, Salaries, Tips, etc.	Social Security, Pensions, & Annuities	Military Family Allotments	Income from business – Self Employment-Taxes	Interest, Dividends, Rental Income	Other Income	Total Income
1.							
2.							
3.							
4.							
5.							
6.							
7.							

Average Monthly Household Income	

Discount approved	**Level A**	**B**	**C**	**D**	**E**

Application Expiration Date:

Income verified by:

_____ _____

WHN Employee Date