CONFIDENTIAL SLIDING SCALE ELIGIBILITY APPLICATION

Patient Name: _____ Social Security # _____

Mailing Address: _____ Date of Birth: _____

_____ Phone: _____

Street Address: _____

The information you give below is confidential. This information will determine if the patient is eligible for sliding scale fees and other subsidized services.

1.) **Does the patient have health insurance?** ◯ Yes ◯ No

If yes:

☐ Medi-Cal
☐ Medi-Cal pending
☐ Other: (please specify) _____

2.) **How many people are in the family?** _____

(A family unit is defined as an individual or a group of two or more persons related by birth, adoption, marriage, or a significant partner who share income and living expenses.)

Name	**Birth Date**	**Relationship**	**Insurance**	**Gross Income**
Self		SELF		

3.) **How much money does the family make before taxes?** $ _____ or $ _____
monthly yearly

Proof of income: (required) ☐ tax return ☐ paycheck stub ☐ Disability/EDD

Do you receive any of the following? Child support ☐ Alimony ☐
Social Security benefits ☐ Pension fund ☐ Rental property income ☐
Worker's Compensation benefits ☐

I certify under penalty of law that the above eligibility information is correct and I acknowledge that deliberately providing false or incomplete information may disqualify me for sliding fee scale consideration:

_____ _____ _____
Signature of patient or responsible party Printed name Date

OFFICE USE ONLY: Reviewed by: _____ Eligible for level _____ , pays _____ POI received _____

POI requested _____ A/C Appointment Date _____

A/C USE ONLY: Certified by: _____ **Eligible for level _____ , pays _____**

Sliding Scale start date: _____ Sliding Scale Good Thru Date: _____

AC assisted with: _____ A/C Signature: _____