MID-DELTA HEALTH SYSTEMS

Application for Reduced Fees

The Sliding Fee Scale is based on your ability to pay. If you wish to participate in the Sliding Fee Scale program, it is necessary for us to ask personal questions regarding financial status. This information will be kept on file within our clinic in strict confidence. You must verify your income at least once every year. Proof of **Total Household** income may include:

- Your yearly income tax return and/or a copy of your W-2 form
- 1 current pay check stub
- A copy of your social security checks/Letter of Award or proof of governmental assistance
- Checks or documents or Other income you may receive

Your annual household income will be used to calculate the level of your discount.

Instruction: Complete entire application, sign, and date.

Responsible Party	**Date of Birth**	**SSN# (Optional**
Address	**City, State, Zip**	**Phone Number**

Marital Status: Single Married Separated Divorced Widow(er)

***TOTAL number living in your household, include yourself: _____**

***Is anyone in your household employed? Yes or No**

Household Income: Include any person that receives 50% of financial support from household.

List Household Members	**Relationship to patient**	**Date of Birth**

I declare the above information is true. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit.

If you do NOT wish to apply for our Sliding Fee Scale:

Mid-Delta is a Federally Qualified Health Center. We are required to obtain household income information for reporting purposes. Please indicate your family's annual income. This helps us report income data even if you are not applying for the sliding fee scale.

____ $0 - $10,000 ____ $10,000 - $20,000 ____ $20,000 - $30,000 ____ $30,000 - $40,000
____ $40,000 - $50,000 ____ $50,000 - $60,000 ____ $60,000 - $70,000 ____ $70,000 - $80,000
____ $80,000 - $90,000 ____ $90,000 - $100,000 ____$100,000 + ____ Wish not to disclose

□ **I refuse to provide my proof of income to apply for the reduced fees. In doing so, I agree that I will be responsible for the bill in full. (ONLY CHECK BOX IF YOU ARE NOT PROVIDING)**

_____ _____ _____

Responsible Party Signature Date Interviewer Signature

OFFICE USE ONLY

Weekly Gross Pay $_____x4.334=
Bi-Weekly Gross Pay $_____x2.167=
Twice Monthly Gross Pay $_____x2.00=
Monthly Gross Pay $_____x 12=
Totals x 12 Months
Total Annual Income: $_____

Expiration Date: _____(1 year from today)