Application for Sliding Fee Discount (SFD)

Name:	Date of Birth:
Address:	Telephone number:
City, State:	Email address:
Zip code:	Do you have Health Insurance? YES or NO

***SFD Household Member-** a person whose residence is in the immediate home and may be legally claimed as a dependent deduction on the parent(s) or guardian's federal income tax return. This is anyone who depends on the financial support of a parent or guardian and who may legally claim the dependent on their federal income tax return.

Total Number of Persons in family/Household*_____

_____

List total annual income of the family household and **Attached Verification**

***SFD Household Income** -the total income that is reported as gross income on the individual, joint, head of household, or married filing separately federal tax return(s). Income would otherwise include all the gross wages, social security, pension payments, interest income, stocks/bonds, other household income, unemployment, rental income, and public aid (SNAP) for all income-earning members of the household, which would otherwise include the dependence income.

***SFD Income Verification-** process by which SFD Applicant's income is verified for placement within the sliding fee discount schedule. The following forms of income level may be used for the verification process:

1. Most Recent Income Tax Return(s) or W-2 of all income earning family members. The sum of Gross Wages on the returns will be used as annual household income.
2. Copies of most current earnings statements (pay stub, either bi-weekly or monthly) from applicable employers and/or government/public assistant entities (Unemployment statement, Social Security, Pension, SNAP benefit summary) or Interest Income, stocks/bonds, rental income, or proof of any other household income. The gross earnings of these types of proof will be used for proper placement into the SFD.

Choose ONE:

- ❑ **Weekly $_____**
- ❑ **Bi-weekly $_____**
- ❑ **Monthly $_____**
- ❑ **Annually $_____**

_____

Applicants for discounted services will be returned if all proof of income is not attached*

I request that Plexus Health determine my eligibility for the sliding fee discount schedule for services provided by Plexus Health. I understand that the information I give is subject to verification by Plexus Health. I also understand that if the information which I give is determined to be false, it will result in denial of the sliding fee discount schedule eligibility, and I will be liable for payment in full.

I declare that the above and attached information is correct to the best of my knowledge. I also understand that my income verification is good for 1 year, and if my income should change that I must notify the receptionist on my next visit to the office.

Applicant signature: _____ Date _____

Official Use Only

I verify that the above information is correct to the best of my ability, and I have reviewed all documents demonstrating proof of income.

Staff Signature : _____ Date_____