



Sliding Fee Scale Application

All patients must provide complete proof of income to be considered for discounts. Failure to do so will result in full (100%) responsibility for all service costs. This information is used **ONLY at HEALS Clinics**, and we will not share your personal information.

Patient's Name:		Date of Birth:		Date:		
Social Security Number:			Age:		Male	Female
Is the patient a Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No		School Name:		Grade		Teacher
Household Income #1 Name:				Household Income #1 Social Security #:		
Home #:		Work #:		Cell #:		
Current Address:	Street		City		State	Zip
County:			How long have you been living here?			
Parent/Guardian Employer:			Hire Date: (month/day/year)			
If unemployed – last date worked (month/day/year)			Reason:			
Household Income #2 Name:			Parent/Guardian #2's Social Security #:			
Home #:		Work #:		Cell #:		
Current Address:	Street		City		State	Zip
County:			How long have you been living here?			
Employer:			Hire Date: (month/day/year)			
If unemployed – last date worked (month/day/year)			Reason:			
Are you Renting?	Buying	Do you Own		Living with and/or supported by someone?		Who?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Number of dependents relying on your income:				Relation to you?		
List the ages of YOUR children still living in the household:						
Have you ever applied for SSI/Social Security Disability?					Date of last application:	

Information to Connect You with Resources

Please check all that apply:

Homeless: Yes No

Public Housing Yes No

Worker Status: Migrant Seasonal Not Migrant/Seasonal Refuse to answer.

Disabled: Yes No

Military Discharge: Yes, Discharge Date _____ No

Refugee Status Yes No

Country of Origin: _____

Patient's Name _____ DOB: _____

MONTHLY INCOME & MONTHLY EXPENSES

This information is for HEALS Clinics ONLY Eligibility is determined based on family size and income compared to Federal Poverty Guidelines. Patients will not be denied services based on an inability to pay.

Income Type	Amount	Expenses/Bills Type	Amount
Monthly Gross wages/unemployment -Income #1		Rent, house, or trailer payment	
Net wages after taxes - Income #1		Land/lot payment	
Gross wages - Income #2		Utilities	Gas
Net wages after taxes - Income #2		Food	Water
Gross wages/salary - Additional Income		Phone Bill	
Net wages after taxes - Additional Income		Car payment	Car Insurance
		Car payment	Car Insurance
		Child support/alimony payment	
Social Security check amount #1		Daycare/childcare expense	
Social Security check amount #2		Education/college loans	
Social Security check amount (child)		List of all insurance premiums paid:	
SSI Income (list amount & recipient)		Hospital/daily indemnity	
Military/Reserves Income		House/renters insurance	
Short/long term disability income		Health/ Medical insurance	
Unemployment check amount		Student insurance	
Retirement/pension check amount		Life/burial insurance	
Rental income receives		Cancer insurance	
AFDC/Family Assistance		Doctor and medical expenses (monthly)	
Church assistance received		Prescription costs (out of pocket)	
Other income or money received		Other expenses:	
TOTAL MONTHLY HOUSEHOLD INCOME:	\$	TOTAL MONTHLY HOUSEHOLD EXPENSES:	\$

Applicant's statement: I do hereby certify that the information on this form is correct and true to the best of my knowledge and that no pertinent items of information have been concealed or omitted from this application. I also understand that HEALS Inc. has the right to reverse its decision concerning charity discounts when discovery of information is made that indicates the patient/guarantors has or had the ability to pay for their services. I am giving HEALS, Inc.; permission to access my credit file and to provide my financial information to those companies contracted by HEALS, Inc. for the purpose of financial or product recovery programs for which I may qualify. If there is anyone you would like to allow us permission to speak with regarding completing the financial application process, please list them below as a designated person in the space provided.

Printed Parent/Guardian's Name

Parent/Guardian's Signature

Witness Signature _____ Date: _____

REQUIRED DOCUMENTS

To apply for the Sliding Fee Discount Program, please provide **current proof of income**. Documentation must reflect your **most recent earnings** and may include **one** or more of the following:

- Most recent **income tax return** or **W-2 form**
- **Two most recent pay stubs**
- **Most recent unemployment check or benefits statement**
- Proof of **other household income** (such as Social Security, pension, disability, or child support)
- **Bank statements** showing direct deposits
- **Self-Declaration of Income Form**, only if no other proof of income is available.

If proof of *gross (before-tax)* income is not available, income may be **estimated based on net income** documentation.