



SLIDING FEE ELIGIBILITY FORM

Mainline Health Systems, Inc. Sliding Fee Program is for patients and their families to pay according to their income. The Federal Poverty Scale is used for determination of level. Please complete the following information so that Mainline Health Systems will be able to determine your eligibility for discounted services. You will be reassessed for the sliding scale annually, and you will be required to provide updated proof of income.

HOUSEHOLD MEMBERS

A "household" includes legal children, a civil union partner, married spouse, and legal dependents. Please list the names of individuals in your household and their relation to you.

Name	Date of Birth	Relationship to Applicant
		Head of Household

ANNUAL HOUSEHOLD INCOME

Please select ONE of the following:

No, I **DO NOT** wish to apply for sliding fee or provide income information

Yes, I **DO** wish to apply for sliding fee and will provide income information (complete table below)
(Please add annual income to applicable spaces)

Type of Income	Self	Spouse	Others
Gross Wages & Salaries	\$	\$	\$
Social Security & Pensions	\$	\$	\$
Unemployment Benefits	\$	\$	\$
Veteran's Benefits	\$	\$	\$
Public Assistance	\$	\$	\$
Other	\$	\$	\$

Do you file a tax return? YES NO

Do you have insurance? YES NO

*I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charged the full fee for my visit if I do not provide income documentation by **10 business days of my first visit**. I understand that I am required to notify Mainline Health Systems if my income level changes or if I become insured.*

Print Name _____

Signature _____

Date _____