**Sliding Fee Discount Application**

It is the policy of Bowdle Healthcare Center to provide essential services regardless of the patient’s ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the business office to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this facility, but not to services or equipment that are purchased from outside. This includes reference laboratory testing, x-ray interpretation by a consulting radiologist and other such services. This form must be completed every 12 months or if your financial situation changes.

|  |  |
| --- | --- |
| Head of Household: | Place of Employment: |
| Address: | City: | State: | Zip: | Phone: |

Number of related persons living in your household: \_\_\_\_\_\_\_\_

Please list spouse and dependents under 18 years of age.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Name** | **Date of Birth** |
| Self |  | Dependent |  |
| Spouse |  | Dependent |  |
| Dependent |  | Dependent |  |
| Dependent |  | Dependent |  |

**Annual Household Income**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Source** | **Self** | **Spouse** | **Children** | **Total** |
| Gross wages, salaries, tips, etc. |  |  |  |  |
| Income from business, self-employment and dependents |  |  |  |  |
| Unemployment compensation, workers’ compensation, social security, supplemental security income, public assistance, veterans’ payments, survivor benefits, pension or retirement income |  |  |  |  |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. |  |  |  |  |
| **Total Income** |  |  |  |  |

Note: Copies of most recent tax return will be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved Discount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_