



Discounted/Sliding Fee Program Application

Name of Head of Household: _____ Phone: _____

Place of Employment: _____

Address*: _____

City: _____ State _____ Zip _____

Please list spouse and dependents under age 18

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Income Information

Source	Self	Spouse	Other	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				

*For verification purposes only, we will require a copy of your driver's license, your most current tax return and copies your last three pay stubs for the income listed above.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before discount is approved.

Name (Print) _____ Date _____

Signature _____

If you have any questions regarding this application, please call our Patient Financial Counselors at 608-342-4717 (Option 2).