

FamilyCare Medical and Dental Sliding Fee Scale Application

Date _____

Please list any income* for the month. Bring the last 90 days of pay stubs or last year's tax return, and any other verification.

Total number of people living in your household _____

PLEASE PRINT all members of the household

First Name, Middle Initial, Last Name	Date of Birth	SS Number	Monthly Income
1. _____	____/____/____	_____ (patient only)	\$ _____
2. _____	____/____/____		\$ _____
3. _____	____/____/____		\$ _____
4. _____	____/____/____		\$ _____
5. _____	____/____/____		\$ _____
6. _____	____/____/____		\$ _____
7. _____	____/____/____		\$ _____

* Income is money earned before taxes (gross income), self-employment income, alimony, child support, retirement, Social Security (SSI), unemployment, Worker's Compensation, interest from savings, dividends from investments, rental income, seasonal employment income, welfare assistance, cash value of Food Stamps, financial assistance from a family member, or any other source of money your family uses to live on. Please include proof of income for the entire household.

This information is true, correct and complete to the best of my knowledge and belief.

Signature _____

Mailing Address (Street) _____

(City/State) _____ (Zip) _____

Telephone _____ Alternate contact _____

Business Office Use Only - Please Do Not Write in This Space

in Household _____ Gross Monthly Income \$ _____ Circle Discount 25% 50% 75%

Effective Date _____ Expiration Date _____ Reviewed by _____

Approved for: Sliding Fee Scale Yes No

Entered in: FamilyCare Tracking
 FamilyCare Dental
 Medical Manager

(circle) card received or card mailed _____
(date)