AIHSC Sliding Fee Discount Application

How the Sliding Fee Discount Program Works

AIHSC is part of national program that lets us discount the cost for our patients' medical and behavioral health visits. *(Laboratory Services are separate charges and must be paid for at the time of visit.)* To see if you can get a discount, you will need to fill out and sign this form.

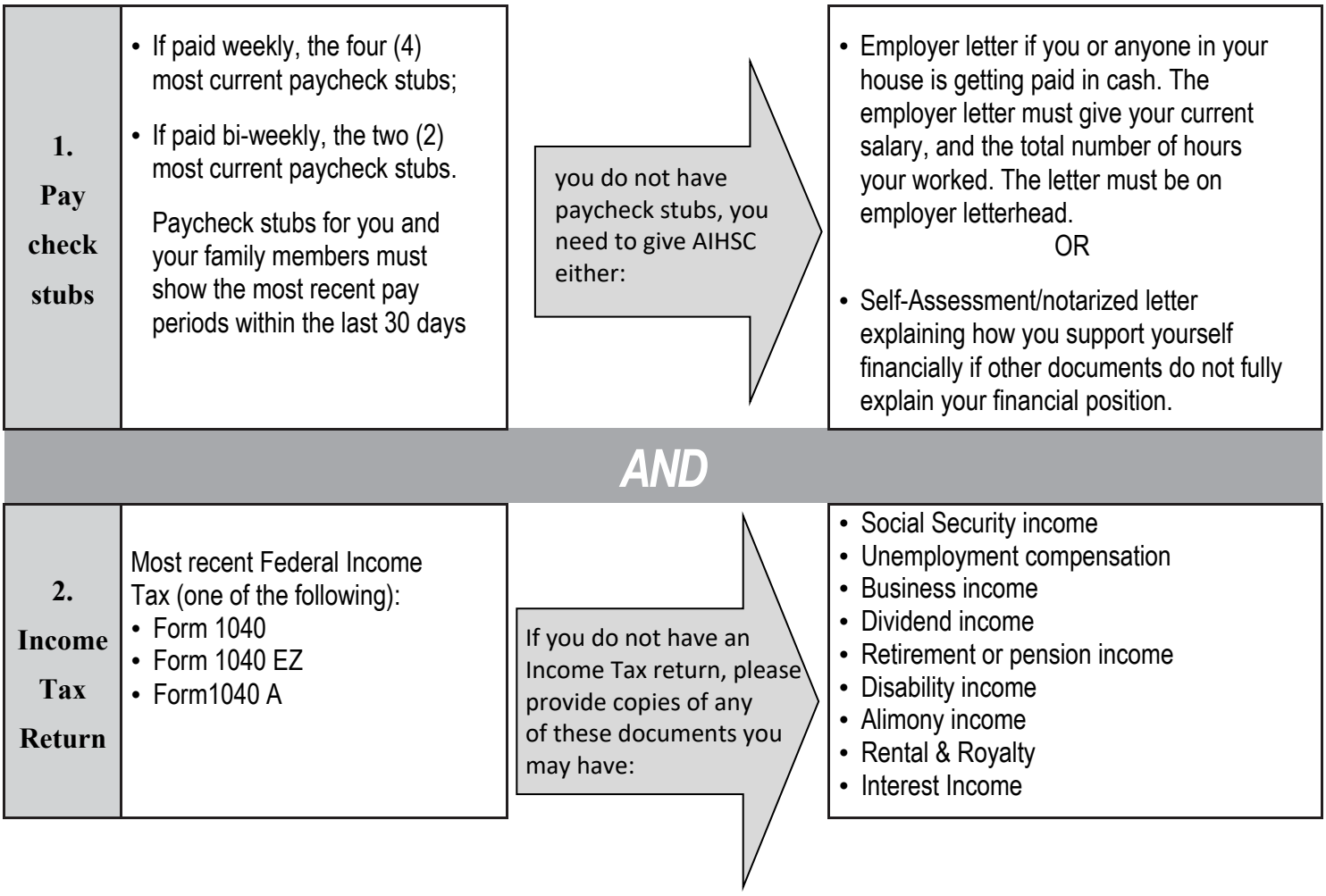
We will ask you for:

- The number of family members living with you including, spouse/partner; parents or in-laws; and dependent children
- How much money each family member earns

We will tell you how much your discount will be when you check in/out at the front desk and help you complete this application if you need it.

Showing How Much Money You Earn

To be part of the program you need to give us proof of the total income of every family member who lives with you before taxes (also called gross income). To figure out your family's total income, you need to submit pay check stubs of all family members living with you and your income tax return or one of the other items described below.



Sliding Fee Scale Application Form

Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #:		Cell Phone #:		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

Household Income			
Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Unemployment Compensation					
Business Income					
Dividend Income					
Retirement or pension income					

NOTE: To comply with federal regulations and to give you a discount on our medical services, it is necessary for us to ask some personal questions.
Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Please bring yearly income tax return, copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive as proof of family income.
Only the family size and annual income will be used to

Sliding Fee Scale Price:

A – $20.00 Visit Fee

B – $35.00 Visit Fee

C – $60.00 Visit Fee

D – $75.00 Visit fee

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform AIHSC if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of AIHSC. I hereby acknowledge that I read the foregoing disclosure and understand it.

Name: (Print): _____ Date: _____

Signature: _____