SLIDING FEE SCALE APPLICATION

It is the policy of Pearl Health Clinic 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 front desk or mail to our office for us to determine if you or members of your family are eligible for a reduced sliding fee.

The reduced sliding fee will apply to all services received at Pearl Health Clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation or radiology services by a consulting radiologist, and other such services.

THIS APPLICATION MUST BE COMPLETED AT THE BEGINNING OF EACH NEW YEAR OR IF YOUR FINACIAL SITUATION CHANGES.

NAME OF HEAD OF HOUSEHOLD *

PLACE OF EMPLOYMENT *

MAILING ADDRESS *

CITY *

STATE *

ZIP *

PATIENT RECEIVING SERVICES *

PHONE *

PLEASE LIST SPOUSE AND DEPENDENTS UNDER AGE OF 18

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH

ANNUAL HOUSEHOLD INCOME

SOURCE

	SELF	SPOUSE	OTHER	TOTAL
Gross (monthly wages, salaries, tips)				

SOURCE

	SELF	SPOUSE	OTHER	TOTAL
Income from Business, self-employment and dependents				

UNEMPLOYEMENT, WORKERS COMPENSATION, SOCIAL SECURITY, SSDI, PUBLIC ASSISTANCE, VERTERAN'S PAYMENTS, SURVIVOR BENEFITS, PENSION OR RETIREMENT INCOME.

TOTAL INCOME	

IMPORTANT!

REQUIRED: COPIES OF TAX RETURNS, 2 MONTHS WORTH OF PAYSTUBS, SSI LETTER, OR OTHER INFORMATION VERIFIYING INCOME IS REQUIRED BEFORE THE SLIDING FEE IS APPROVED.

APPLICATION CANNOT BE PROCESSED WITHOUT THIS INFORMATION

IF APPLICATION IS APPROVED, YOU ARE RESPONSIBLE FOR THE DISCOUNTED AMOUNT AT THE TIME OF EACH APPOINTMENT. FAILURE TO PAY YOUR RESPONSIBLE AMOUNT MAY RESULT IN YOUR SLIDING FEE SCALE BEING DISCONTINUED.

I CERTIFY THAT THE FAMILY SIZE AND INCOME INFORMATION SHOWN ABOVE ARE CORRECT.

NAME (PRINT) *

DATE: *

SIGNATURE OF PATIENT OR PARENT/GUARDIAN OF PATIENT *

FOR OFFICE USE ONLY

ACCOUNT #

APPROVED PATIENT RESPONSIBILITY

EFFECTIVE DATES

SIGNED

DATE

REVISED 12/23/2020