Clarity Healthcare

APPLICATION FOR SLIDING SCALE

Name _____

Birth Date _____ SSN_____

Address _____

Phone # _____

Marital Status (circle one): Single Married Separated Widowed Divorced

Employment Status (circle one): Employed Unemployed Retired Disabled

LIST ALL Members of household; include all persons living in that household (related or non-related).

Name	Relationship

Sources of Income

- **Wages (W2's, Tax Returns, letter from employer, other)**
- **Gross Wages/Salaries/Tips**
- **Unemployment Compensation**
- **Worker's Compensation**
- **Earnings from need-based employment programs**
- **Welfare Benefits**
- **Social Security**
- **Supplemental Security Income**
- **Survivor's Benefits**
- **Pensions**
- **Veteran's Benefits**
- **Regular Contributions from persons not living in household**
- **Any other income not included in the above list**

All Sliding Fees Are Due at Time of Service

Signature needed on Page 2

Medical Services
Slide A-$20 per Visit
Slide B-$25 per Visit
Slide C-$30 per Visit
Slide D-$35 per Visit
Slide E-$40 per Visit

***Lab only visits are included in the office visit sliding fee charge ***

Behavioral Health Services
Evaluation and Medication Management:
Slide A-$20 per Visit
Slide B-$25 per Visit
Slide C-$30 per Visit
Slide D-$35 per Visit
Slide E-$40 per Visit

Counseling Services
$10 on all Slide levels

Dental Services
Initial Assessment-$15 for All Slide Levels
Dental Procedures:
Slide A-30% of Charges
Slide B-40% of Charges
Slide C-50% of Charges
Slide D-60% of Charges
Slide E-70% of Charges

Some services are not included in the sliding fee program

All Sliding Fees Are Due at Time of Service

I have read and completed the attached form and ensure that the information I entered is true and complete to the best of my knowledge. In addition, I have attached verification of all household income sources in order for this application to be processed. I understand completion of this form does not guarantee a discount, and if I do not qualify for a discount I agree to pay in full or set up a payment plan. If my financial status changes, I agree to inform Clarity Healthcare with current documentation of my financial status at my next visit. I also agree to provide updated income verification as often as possible. All Information submitted will remain confidential.
I understand that if I qualify for the sliding scale program, the minimum due could be a payment of $20 per appointment.

Signature of Applicant_____

Date _____

Total Annual Household Income _____

Approved Sliding Scale Amount _____

Employee Signature _____

Slide Expires on 06/30/2021