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**

Proof of Income

Proof of income should include one or more of the following documentation:

- **Two recent paystubs**
- **Adjusted gross income from the prior year's tax return (if it is reflective of current income)**
- **Bank statement reflecting electronic deposit (for income other than employment income)**
- **Statement of Benefits**
- **Employer earnings statement**
- **Federal or State Award Letter**
- **College award letter with total amount of award**

Medical & Behavioral Health Services

Slide A $15 per visit*
Slide B $20 per visit*
Slide C $25 per visit*
Slide D $30 per visit*
Slide E $35 per visit*

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

Therapy visits

$10 per visit – all slide levels

Dental Services

Initial Assessment: $15 fee – 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

Total Annual Household Income $_____

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. If you are unprepared to show proof of income you have a 30 day grace period, however, if you fail to show proof of stated income within the 30 day period then the patient will be responsible for the full charges of any services rendered after the 30 day temporary slide.

In addition, I understand that if I qualify for the sliding scale program, the minimum due could be a payment of $15 per appointment.

Signature of Applicant_____Date_____

Approved Sliding Scale Amount _____

All information submitted will remain confidential