SLIDING SCALE FEE APPLICATION

Today's Date		Name		
Date of Birth		Address		
City		State	ZIP Code	
Home Phone		Work Phone	Cell Phone	

Please list all immediate family members and persons living in your household (spouse or life partner and children that are under the age of 21 years) and that are dependent on family income. Please do not include guests, elderly parents or roommates.

Name of Family Members		Date of Birth		
1. (Self)				
2. (Spouse)				
3. (Child)				
4. (Child)				
5. (Child)				

What is your gross family income BEFORE deductions (please include all working adults, above age 21)?

Household Family Income	Estimated Annual income (per person) (Monthly Income x 12)	Sources of Income	Proof of Income Date Requested/ Date Verified	FFHC Staff Notes
1. (Self)	$			
2.	$			
3.	$			

Other Determining Factors:

I certify that the income and household composition information is true and correct to the best of my knowledge.

Applicant Signature		Date	

Please bring your proof of income within 7 days of submitting the application.

FIDDLEHEAD FAMILY HEALTH CARE offers a Sliding Fee Scale Discount program for those who apply and qualify. We will honor requests for sliding scale for anyone whose family income is less than 200% of the federal poverty guidelines per household. Please contact us if there are special circumstances, and we will do our best to accommodate your needs.

STAFF USE ONLY–This form will be shredded after evaluation.