Foothills Health & Wellness Center

Self-Attestation of Income for Sliding Fee Consideration

If you do not wish to be considered for *Foothills Health & Wellness Sliding Fee Discount Program* please sign below, If you cannot provide documentation of your household income please complete entire form.

Signature of Applicant: _____ Date: _____

Patient Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

All items below must be answered in order to complete your Sliding Fee Scale Application at Foothills Health and Wellness Center.

How is your payment received? ____ **Cash** ____ **Check**

How often do you get paid? ____ **Bi-Weekly** ____ **Weekly** ____ **Other**

What is the gross amount? **$** _____

Where do you receive your income from? (check all that apply)

- ____ **Wages from Employment**
- ____ **Self-Employment Wages**
- ____ **Social Security Checks**
- ____ **Disability Checks**
- ____ **Farming Income**
- ____ **SSI**
- ____ **VA Pension**
- ____ **Retirement**
- ____ **Black Lung**
- ____ **Alimony**
- ____ **Child Support**
- ____ **Military Wages**
- ____ **Unemployment**
- ____ **Rental Property**
- ____ **Other (Please explain)** _____

Applicants (Recipients must read the following and sign below):

I certify that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for *Foothills Health and Wellness Center Sliding Fee Discount Program* .

Signature of Applicant: _____ Date: _____