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
- ____ Other (Please explain) _____
- ____ Retirement
- ____ Black Lung
- ____ Alimony
- ____ Child Support
- ____ Military Wages
- ____ Unemployment
- ____ Rental Property

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: _____

revised: 12/10/2024