Foothills Health & Wellness Center

Confidential Financial Statement/Sliding Fee Scale Application

Patient Name: _____ DOB: _____ Date: _____

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

Please complete the following statements as accurately and completely as possible. *Foothills Health & Wellness Center* reserves the right to withdraw discounts for failure to provide correct information. It is your responsibility to inform us immediately of any changes in income and/or insurance status or household size.

Foothills Health & Wellness Center is required by the Bureau of Primary Healthcare to obtain proof of income from patients annually. We use the proof of income, along with the information gathered on this form, to determine the amount we can discount the fees charged to you and your family. WE CANNOT PROVIDE A DISCOUNT WITHOUT THIS INFORMATION. Today's visit will be discounted based on the information provided below. If you do not have documentation for today's visit, you will be considered self-pay until verification of your income and residence is received [must be received by 60 days] and responsible for the cost of all services provided. (Initial)_____.

The information contained on this form is protected under HIPPA legislation. It will be used only for the purposes of determining the level of discount provided and to enroll you in prescription patient assistance programs as needed. Your signature at the conclusion of this form indicates your consent for the sharing of this information with necessary pharmaceutical companies.

Please list all members residing in your household (including yourself):

Name	Date of Birth
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

How many members in the household work? _____

Does anyone in the household receive money from the following?

Wages from Employment	___Yes	___No	Retirement	___Yes	___No
Self-Employment Wages	___Yes	___No	Black Lung	___Yes	___No
Social Security Checks	___Yes	___No	Alimony	___Yes	___No
Disability Checks	___Yes	___No	Child Support	___Yes	___No
Farming Income	___Yes	___No	Military Wages	___Yes	___No
SSI	___Yes	___No	Unemployment	___Yes	___No
VA Pension	___Yes	___No	Rental Property	___Yes	___No
Interest Income	___Yes	___No	Worker's Comp.	___Yes	___No

If your household has no income, who pays your monthly bills?_____

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******FOR CLINIC USE ONLY (TO BE COMPLETED BY THE INTERVIEWER)******

Income Source HH member Amount Yearly Income

_____	X	_____	=	_____
_____	X	_____	=	_____
_____	X	_____	=	_____
_____	X	_____	=	_____
_____	X	_____	=	_____

TOTAL YEARLY INCOME: $ _____

Percentage of Poverty:_____%

SLIDING FEE LEVEL APPROVED:_____ **EXPIRATION DATE:_____**

INTERVIEWER SIGNATURE:_____ **DATE:_____**

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