# FAMILY MEDICINE
# SLIDING FEE SCALE
# ELIGIBILITY QUESTIONNAIRE

**DATE FORM COMPLETED: _____**

**PATIENT'S NAME: _____**

**GUARANTOR'S NAME: _____**

**ADDRESS: _____**

_____

_____

**TELEPHONE NUMBER: _____**

**HOUSEHOLD INCOME: $_____**

**FAMILY SIZE: _____**

**For Office Use Only**

**Documentation Needed**
**Tax Return** □
**Pay Stubs** □

**Information must be returned by**

_____

**Follow up call made**

_____

**Payment made** ☐

_____

**List all members of your household, including yourself.**
**People listed must reside in your household and be your financial responsibility.**

| Name | Date of Birth | Name | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please use the back of page for more household members. ☐ Check if you added on back

**TYPE OF INCOME RECEIVED BY HOUSEHOLD**

| Source of Income | Applicant | Spouse/Partner | Other | Additional Information: |
|---|---|---|---|---|
| Salary/Wages | Hours/Week:<br>Wage/Salary: $ | Hours/Week:<br>Wage/Salary: $ | Hours/Week:<br>Wage/Salary: $ | |
| Self-Employment | $ /Month | $ /Month | $ /Month | |
| Unemployment | $ /Month | $ /Month | $ /Month | |
| Child Support/Alimony | $ /Month | $ /Month | $ /Month | |
| Social Security/Disability | $ /Month | $ /Month | $ /Month | |
| Public Assistance (ex. Food Stamps, Energy Assistance) | $ /Month | $ /Month | $ /Month | |

**The preceding information is true to the best of my knowledge. I acknowledge my responsibility to pay for care according to the fees established.**

_____ _____

**SIGNATURE OF RESPONSIBLE PARTY** **DATE**

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| | | |
|---|---|---|
| Proof of Income: | | |
| Verified by: | Date: | |
| Approved: | Denied: | |
| Level of Discount Applied: | | |