SLIDING SCALE APPLICATION

CLIENT DEMOGRAPHICS:

Full Name: _____

Date of Birth: _____

Address: _____

Email Address: _____

Provider Requested for Services: _____

You must provide proof of income to qualify for the sliding scale application. This information must be updated at least annually, and any time your household income size and/or medical insurance status changes. You will be responsible for the full amount of the visit and the discount will not be applied to your account until you give IFW the required proof of income. If proof of income is given to us within 30 days of the visit, and if you are eligible, the discount will be applied retroactively and all following visits will be discounted. Proof of income includes: prior year completed income tax forms, pay stubs from the last three months, unemployment or other benefits income receipts, and/or letters of income verification from two other individuals or from the employer(s). List your name and the names of ALL individuals who live with you. Name, Relationship, Age, Gender, Date of Birth, Annual Income, Employer, SELF. If you need more space, please continue on the back of this form.

INCOME:

Are you currently employed? ___ Yes ___ No

Do you work seasonally only?___Yes ___No

How much money do you and all who live in your household bring in per

Week $ _____ Month $ _____ Year $ _____

If you are not working, how are you meeting your monthly expenses?

___ Savings ___Borrowing ___Other

Do you have health insurance? ___Yes ___No

If yes, what is the deductible amount? $ _____

If yes, what health insurance do you have: _____

List ALL that you, and those living in your household receive:

(Amount per month/year Salary or wages)

$ _____ Unemployment

$ _____ Social Security

$ _____ Pension/Retirement

$ _____ Rental Income/Dividends

$ _____ Spousal Support

$ _____ Child Support

$ _____ Foster Care

$ _____ Self-Employed (net amount)

$ _____ Worker's Comp Benefits

$ _____ Disability Benefits

$ _____ Other

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YOUR STORY

Please provide us with your personal story so we can better understand your situation as a whole when determining how we can serve you.

PLEASE READ AND SIGN

I authorize all government agencies, employers, and any companies or agencies or persons listed herein to provide information about me to Innovations Family Wellness, INC. (IFW). I also authorize IFW to disclose this information to agencies, third-party payers, and other health care providers as necessary to qualify me for reduced fees. I certify that the statements regarding the persons and income in my household are true and correct to the best of my knowledge. I further understand if any information is found to be inaccurate, I may be denied a discount and/or subject to legal action for knowingly providing false information. I agree to notify IFW of all changes in income, address, living arrangements, number of household members, and/or other circumstances. I understand that the information given above will be kept confidential except for the purposes noted above and not be released without my written permission. I also understand that if I do not agree with any decision made concerning this application, I have the right to ask in writing for a review by the CEO.

Signature: _____ Date: _____

Thank you for letting us serve you and your family!

innovations
FAMILY WELLNESS