ForrestHealth®

FORREST HEALTH CLINICS
SLIDING FEE DISCOUNT APPLICATION

It is the policy of Forrest Health Clinics to provide essential services regardless of the patient's inability to pay. Discounts are offered based on family size and annual income. Please complete the following application and return to the front desk to determine eligibility for discounted services.

The discount will apply to all services at this clinic. This form must be completed every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD:		PLACE OF EMPLOYMENT:		
STREET ADDRESS:	CITY:	STATE:	ZIP:	PHONE:

Please list spouse and dependent(s) under age 18.

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security, public assistance, veterans' payments, survivor benefits, pension or retirement				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total income				

Note: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name: _____

Signature: _____ Date: _____

_____

OFFICIAL USE ONLY

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance cards		