

Chart No	
Clinic Location	

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Applicant								
Name		Last	Fir	rst		N	liddle Initial	
Address_								
	Apt. No.			City			Zip code	
Social Se	curity #	Ho	ome Phone No		Ce	ell Phone No		
	PLEAS	E LIST ALL M	EMBERS IN YOUR H	iousi	EHOLD INCI	LUDING YOUF	RSELF	
BCHF MR No.		NAM	IE	APPLICANT RELATIONSHIP		DATE OF BIRTH	DOES THIS PERSON HAVE HEALTH INSURANCE	
							□ Yes □ No	
							□ Yes □ No	
							□ Yes □ No	
							□ Yes □ No	
							□ Yes □ No	
							□ Yes □ No	
							□ Yes □ No	
							□ Yes □ No	
		Т	OTAL NUMBER OF FA	AMILY	MEMBERS #			
			of the household mu	-				
	nt Tax Return Check Stubs	Worker's Compe Military/Vete			Public	nent/Disability Assistance	Employment Letter In Kind Living Support	
<u>Self-</u>	<u>Employment</u>	Social Secur	ity <u>Pension/Reti</u>	<u>irement</u>	<u></u>	t <u>/Temporary</u> ort Letter	<u>Other</u>	
	NAMI	Ē	SOURCE OF INCOMI	E	FREQUENCY (WEEKLY, BI-WEEKLY, TWICE A MONTH, MONTHLY)		(Office Use Only) TOTAL ANNUAL INCOME	
						\$		
						\$		
						\$		
						\$		
			TOTAL ANNUAL					
untrue,	, misleading ed according	or incomplete, to the stablish	on is complete and , I understand that I ned fee schedule. By es needed to substa	may l y sign	be required ing below, l	to pay full pr give my con	ice for the services	
Applica	ant Signature					Date		

certify that I aske household before u	sing this form, and	d that I	made the b	est efforts to o	btain all	other possible
sources of docume were provided solel						
	DOCUMENTS	PROVIE	DED IN THE	APPLICATION:		
PROOF OF INCOME	☐ Profit & Loss (3 months)		□ Alimony		☐ In Kind Donation of Room and Board	
□ Tax Return	☐ Public Assistance (Cal-Works)		☐ Child Supp	ort	☐ Cash Gift or Tempor Support	
□ W-2 Form	☐ Social Security (SSA, SSD,SSI,RS	iDI)	☐ Military fam	ily allotments	□ Savings	
□ 1099 MIC.,1099 INT.	☐ Unemployment		☐ Royalties & payments	Annuity	□ Inheritance	
□ Pay check stubs	☐ Workers Compens	sation	☐ Interests & payments	Dividends	☐ Sale of Property	
□ Employment Letter	☐ State Disability		☐ Income from	n rents	☐ Gifts Income	
☐ Self Declaration of Income	☐ Pension/Retireme	nt				
Calculation and Note	9 S:					
Family Size: Total G		Gross Annual	Household Inc	ome		
Sliding Fee Level:	Nominal Fee \$	Dental Fee \$ Or %		Effective:		Expires:
Processed by	•			Date		

FOR OFFICE USE ONLY

Chart No._____ Patient Name_