WindRose Health Network

Sliding Fee Scale Application

Name			Social Security #
Street			
City	State	Zip	HOME PH: ( ) CELL PH: ( )
Do you have Health Insurance? Yes / No	If Yes, what is the name of your Insurance Company:		

LIST SPOUSE AND DEPENDENTS UNDER AGE 19

Spouse:	Date of Birth:	
Dependent:	Date of Birth:	Covered by Medicaid? YES or NO
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Dependent:	Date of Birth:	Covered by Medicaid? YES or NO

ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross Wages, Salaries, Tips, etc.				
Social Security, Pensions, Annuity and Veteran's Benefits				
Alimony, Child Support, Military Family Allotments				
Income from business – Self Employment				
Rent, Interest, Dividend and Other Investment Income				
Other Income				
TOTAL INCOME	$	$	$	$

VERIFICATION CHECKLIST (ATTACH COPIES)

IDENTIFICATION: Driver's License, Birth Certificate, Employment ID, Social Security Card or other	YES	NO
INCOME: Prior year tax return or W-2s, three most recent pay stubs, or other	YES	NO
NOTE: If income cannot be verified by any written proof listed above, does the patient / guarantor self-attest that the above information is true?	YES	NO

I certify the information shown above is accurate and true. I understand that if I have provided false information, my account will default to the full amount due for services rendered. I also understand that this application is good for six (6) months, after which time, I will be asked to update my information.

Date_____ **Patient/Guarantor Signature**_____

OFFICE USE ONLY

Effective Date	**Discount Approved**	**MIN**	**75**	**50**	**25**	**0**
Expiration Date	**Approved By**					