Crossroad Health Center Sliding Scale Application

Patient Name _____ Date of Birth _____

What is your Family size? _____

If you do not have proof of income, please estimate how much money do you earn/receive?

$_____

How often do you earn/receive this? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually

If proof of income is brought:

Check One	Type of Proof	Income Amount	Pay Period Length
☐	Pay Stub from Job; Bring most recent one		
☐	Letter from work stating income earned		
☐	W2 Form		Annual
☐	Self employed- Bring wage statement you give to IRS		
☐	Get Child Support? Bring statement		
☐	Unemployment Benefits? Bring statement		
☐	Social Security (SSI, SSDI, SSRI)? Bring statement		
☐	Foster Care statement from Job & Family Services		
☐	Stipend from school or Military. Bring statement		
☐	I live in a shelter. Bring in a letter from them.		
☐	I receive food stamps OR have Section 8 Housing. Bring in document from the agency.		
☐	I receive support from family/friends. Bring a statement from them.		

You MUST bring in proof--- we are UNABLE to provide you with a sliding fee scale without it!

_____ I understand that if I fail to bring in PROOF of income for my next visit (or within 30 days) and wish to be seen, I will be required to pay $50 as a partial payment for that day's visit. The remainder cost will be billed to me (typically another $50-$100). I will NOT be able to get the sliding scale until I bring in proof.

_____ I understand that I must pay my COPAY (sliding scale fee) at EACH visit.

Patient/Guardian Signature: _____ **Date:** _____ **Witness:** _____

For office use only

Slide Expires on: _____