EOMHC's Sliding Fee Schedule Application

Sliding Fee Discount Information

It is the policy of EOMHC to provide essential services regardless of the patient's ability to pay. EOMHC offers discounts based on family size and annual income.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

NAME _____

STREET _____**CITY** _____

STATE _____**ZIP** _____**PHONE** _____

Please list all household members, including those under age 18.

	Name	**Date of Birth**
Self		
Other		
Other		
Other		
Other		
Other		
Other		

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

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

Name (Print)_____ Signature_____ Date_____

----------OFFICE USE ONLY----------

Client 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		

Self-declaration of income may also be used.