PEARL HEALTH CLINIC SLIDING FEE DISCOUNT APPLICATION:

NAME OF HEAD OF HOUSEHOLD **PLACE OF EMPLOYMENT**

____ ____

MAILING ADDRESS

____ CITY____________STATE_________ZIP______________

PHONE:

____

PLEASE LIST SPOUSE AND DEPENDENTS UNDER AGE 18

NAME DATE OF BIRTH NAME DATE OF BIRTH

____ ____

NAME DATE OF BIRTH NAME DATE OF BIRTH

____ ____

NAME DATE OF BIRTH NAME DATE OF BIRTH

____ ____

NAME DATE OF BIRTH NAME DATE OF BIRTH

____ ____

ANNUAL HOUSEHOLD INCOME:

SOURCE	SELF	SPOUSE	OTHER	TOTAL
GROSS monthly wages, salaries, tips, etc.,				

Income from Business, self-employment and dependents

Source	**Self**	**Spouse**	**Other**	**Total**

Unemployment, workers compensation, social security, SSDI, public assistance, veteran's payments, survivor benefits, pension or retirement income

TOTAL INCOME				

NOTE: Copies of tax returns, pay stubs, or other information verifying income is required before discount is approved. Please attach with application. Application cannot be processed without this information.

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

NAME (PRINT)	SIGNATURE	DATE

____

Office use only

Patient name: ____

Approved Discount: ____

Approved by: ____**Date**_____________

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