



FINANCIAL STATEMENT FOR SLIDING SCALE APPLICATION

Policy: It is the policy of Mountain Medical Center to provide essential medical services regardless of the patient's ability to pay. Discounts are offered based upon household income and size. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for six months, after which the patient must reapply.

Discount Application Process: A completed application including required documentation of the home address, household income, and insurance coverage must be on file and approved by the business office before a discount will be granted. If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required.

General Instructions: Please complete the form in its entirety, sign at the bottom, and return it to the clinic prior to your scheduled appointment. Please be aware that if you qualify for a Sliding Scale, *that scale will apply only to office visit charges* and not to additional laboratory testing or procedures performed. Medication samples will also be provided, when available, without charge.

Name (head of household)	Address	Phone	Soc. Sec. #	Date of Birth
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Employer Name & Address	Phone	Occupation	How Long
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Pay Day	Take Home Pay Per Payday	Monthly Take Home Pay
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Name of Spouse	Address	Phone	Soc. Sec. #	Date of Birth
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Employer Name & Address	Phone	Occupation	How Long
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Pay Day	Take Home Pay Per Payday	Monthly Take Home Pay
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Family Status (check one)

Single
 Married
 Separated
 Divorced
 Widow
 Widower

Number of persons in your household that you support:

Adults _____ Children _____ Ages _____

Family Member's Name	Social Security or Alien Number	Date of Birth

Mountain Medical Center



HOUSEHOLD INCOME				
List all Income On a Monthly Basis				
Source of Income	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Self Employed Income				
Social Security, pension, annuity, & veteran's benefits				
Unemployment				
Alimony, Child Support, military family allotments				
Workman's Compensation				
Rent, interest, dividend, and other income				

I/we hereby certify that the information listed herein is true and correct to the best of my/our knowledge and give Mountain Medical Center my/our permission to verify any information listed.

Date Signature

Date Signature

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's License, birth certificate, employment ID, social security card, or other		
Income: Prior year tax return & three most recent pay stubs		
Medicaid: Application made or evidence of rejection		

Thank you for your completed application.

You will be notified within two business days of the acceptance/rejection of your application.

Office Use Only		
Patient Name:	Discount:	Approved By: