SLIDING SCALE FEE APPLICATION

Kindred Treatment Center

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Sliding Fee Discount Application

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

Please complete the following information and return it 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 KTC, 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.

Patient Information						**Today's Date: / /**					
First Name:		Middle:		Last:			Other names:				
Home Address:				City:			State:	Zip:			
Mailing Address:				City:			State:	Zip:			
Home Phone #:	( )		-	Home Phone #: (	)	-					
Date of Birth:	/ /		Social Security #		Do you have insurance? (circle one)		Yes	No			

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

HOUSEHOLD

NAME	DATE OF BIRTH	RELATIONSHIP TO APPLICANT
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	- -

Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

TYPE OF INCOME STATUS DOCUMENTATION REQUIRED

Written verification for each source of income is required within 30 days in order to process your sliding fee application. Without verification, your account will not be discounted; $50 deposit is requested prior to receiving services. Income verification must include GROSS INCOME. Acceptable forms of written income verification include: Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program. I further agree to inform Kindred Treatment Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Kindred Treatment Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____

(Print Name):_____

Signature:_____

OFFICE USE ONLY

Patient Name: _____

Approved Discount %:_____

Approved by: _____

Date Approved: _____

Documents Accepted as Proof of Income (POI):

□ **Current Pay Stubs-within 90 days (minimum: 3 pay stubs)**
□ **W2 Tax Form** □ **Tax Return Form #1040 (Line 9) (total income)**
□ **Tax Return Form #1040SR (Line 9) (total income)**
□ **Social Security (Staff: READ Contents of Letter)**
□ **Unemployment (for 6 months)**
□ **Letter from Employer**

If You Attest to No Income, Please Check Means of Support:

□ **Disability**
□ **Child Support**
□ **Workers Compensation**
□ **Temporary Cash Assistance**
□ **551 (Supplemental Security Income)**
□ **Social Security Disability**
□ **Live with other family member**
□ **Other** _____

Verification Checklist	Yes	No
Identification/Address: (Driver's license, utility bill, employment identification, or Other)		
Income: (Prior year tax return, three most recent pay stubs, or other)		