CATALYST CLINICAL GROUP

Sliding Fee Scale Application

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: / /		Do you have insurance? (circle one) Yes No		
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

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.
Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

Household 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					
Interest Income					
Child Support, Alimony					
Other					
				TOTAL	**$**

Sliding Fee Scale:

A – 100% Pay

B – 80% Pay

C – 60% Pay

D – 40% Pay

E – 20% Pay

F – 0% Pay

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 CATALYST CLINICAL GROUP 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 CATALYST CLINICAL GROUP I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____ Name (Print):_____

Signature:_____

OFFICE USE ONLY

PATIENT 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		
Insurance: Insurance Cards		