ANGEL HARVEY
FAMILY HEALTH CENTER
INFANT WELFARE SOCIETY *of* CHICAGO

Sliding Fee Discount Application

Patient Information			Today's Date: / /		
First Name:	Middle:	Last:	Other names:		
Home Address:		City:	State:	Zip:	
Mailing Address:		City:	State:	Zip:	
Home Phone #: ( ) -		Cell Phone #: ( ) -			
Date of Birth: / /	Social Security # - -		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 enough 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					
Retirement Pension					
Child Support, Alimony					
Interest Income					
Unemployment					
Rentals					
Other					
				TOTAL	**$**

ATTENTION: If income verification is not provided on the day of application, you must provide it within 30 days of the application for the sliding fee to be applied retroactively to your visit. Failure to provide income verification within the 30 days will result in the denial of your application and the cost of the visit will be solely your responsibility.

ANGEL HARVEY
FAMILY HEALTH CENTER
INFANT WELFARE SOCIETY *of* CHICAGO

Sliding fee discount approval form

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 and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Infant Welfare Society of Chicago 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 Infant Welfare Society of Chicago. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____________________ Name (Print):____

Signature:____

Internal use only

Sliding Fee:

Medical: _____________ Family Planning: ____________ Dental: ____________

Proof of income provided (circle all that apply):

1. Verbal Income – Must provide proof of income within 30 days
2. Most recent tax returns (all pages)
3. Current pay stubs (last 4 weeks)
4. Letter from the employer on their letterhead stating your gross earnings
5. Unemployment letter
6. Social Security earning statement
7. Self-employment form

Effective date: ____________________ Expiration date: ___________________

____
Patient Signature

____
Signature of staff making eligibility determination

Final approval date: ___________________ by Director/Supervisor__________________