Sliding Fee Discount Program Patient Application

Steck Medical Clinic

It is the policy of Steck Medical Clinic to provide services regardless of the patient's ability to pay. A discount is offered based on family size and annual income.

Please complete all 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 this clinic, but not services or equipment supplied from outside, including laboratory testing, drugs, imaging, and other such services. You must complete this form every 12 months or if your financial situation changes.

Please supply prior years tax return, three most recent pay stubs, and a form of patient identification.

Name: ______________________ DOB: ______________

Street: ______________________ City: ______________

State: ____________ Zip: ____________ Phone: ______________

Signature: ______________________ Date: ______________

Please list all household members, including those under age 18.

Relationship	Name	Date of Birth
Self		

Source	Self	Other	Total
Gross wages, salaries, tips, ect.			
Income from business and self-employment			
Unemployment compensation, worker's compensation, social security, supplemental security income, veterans'' payments, survivor benefits, pension, or retirement income			
Interest, dividends, royalties, income from rental properties, estates, and trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources			

Total income			

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

Name: ______________________________ Date: ______________

Signature: ____

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Office use only

Patient Name: ________________________________

Approved Discount: ____________________________

Approved by: _________________________________

Approved Date: _______________________________

Verification Check List

- ○ Prior year tax return
- ○ Three most recent pay stubs
- ○ Patient identification