



Sliding Fee Discount Application

Complete this form if you would like to apply for a sliding fee discount. You must bring proof of income for us to determine if you qualify. **Not all dental services are discounted—if in doubt, please ask.**

Person Responsible for this account: _____ Patient Name: _____
Total persons in your household? _____ *List the names of those persons below. Circle those who should be listed on your account.*

Name: _____	Relationship: _____	Place of Work: _____	FT/PT
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Name: _____	Relationship: _____	Place of Work: _____	FT/PT
Name: _____	Relationship: _____	Place of Work: _____	FT/PT

Proof of Income (please check all that apply and attach copies):

- Pay Stubs (For every pay period for the last three months)
- Letter from your Employer if you are paid in cash
- Social Security Disability Letter or Social Security Retirement Letter
- Wage Record or Employment History Report (From Employment Office) if you are not employed
- Unemployment Compensation Check Stubs
- Copy of your Taxes from last year
- Copy of your last W-2
- Other _____
- I am unable to provide proof of income because:

Klamath Open Door Clinic is partially federally funded. We are required to obtain the following information for government reporting purposes. Please be assured, all information will be kept strictly confidential.

Is patient Homeless (Yes or No): _____ Patient's Primary Language: _____
 Are you an Agricultural Migrant or Seasonal Worker or the dependent of one? (Yes or No): _____
 Patient's Ethnic Background: _____ Patient's Race: _____

I certify that my total household income is an average of \$ _____ per month/year. THIS COVERS MYSELF AND ALL MY FAMILY MEMBERS ON MY ACCOUNT FOR THE YEAR _____.

I CERTIFY THIS IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I understand that I may qualify for discounted charges (in accordance with federal guidelines). If my total household income and/or total amount of household members should change, I agree to report these changes to Klamath Open Door Family Practice.

Responsible Party Signature **Date**

For Office Use Only

Family Size: _____ Total Household Income: _____ p/year, month, week (x.4.33)
 % of FPL: _____
 Approved By: _____
 Effective Date: _____ Renewal Date: _____
 Income Verified By: Pay Stub, Check, Bank Statement, Letter of Employment, W-2 Form