Wade Location: □ **Medical (includes Behavioral Health)** □ **Stedman Family Dental**
Fayetteville Location: □

Sliding Fee Application

[To be completed by patient/guardian. Please complete ALL family information below.]

Patient Name: _____ Date of Birth: _____/_____/_____

Date of Application: _____/_____/_____

							For Internal Use Only	
Name	**Family Relation**	**Date of Birth**	**ID Number (DL, etc)**	**Income**	**Frequency**	**Type of Income Documentation**	**Date all Documentation Received/Verified**	**Documentation Received By**

I understand that the information I provide on this form is subject to verification by SWHS, Inc. I certify that the above information is true and correct to the best of my knowledge and that I have read and understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.

_____ _____

Patient/Guardian Signature **Printed Name** **Date**

(DO NOT write below this line. To be completed by SWHS, Inc.)

	Acceptable Income Documentation [Enter (x) if verified and obtained]	**Calculated Amount Associated w/Documentation**
	Current Federal Tax Return	
	Check stub(s) with employer name, income, socials security #, hours worked, and rate of pay; weekly income*# of weeks/12=.	
	Company letter stating annual earnings (Letter must contain a contact person and phone number for contact.	
	Official Letters/documents from Social Security, Courts, Child Support, ESC, etc.	
	Total Income Amount	

Total Number of Family Members Applying for the Sliding Fee Program	

Enter (x) if verified and obtained	**Verified and Obtained Information**
	Acceptable identification for each family member listed on Sliding Fee Program Application
	All family member(s) name(s) and date(s) of birth listed on Sliding Fee Program Application.

Qualified Poverty Percentage	**Medical/Dental Slide Category**	**Slide Effective Date**	**Slide Termination Date**

_____ _____

Signature of SWHS, Inc. Staff **Date**