Sliding Fee Application

SOLVERA HEALTH

Patient Demographics

First Name M.I. Last Name _____ Date of Birth ___-___-____ Social Security #

(___)___-____ Primary Phone Number _____ Email Address

Address _____ City _____ State _____ ZIP

Income Information

Personal Income Information

$ _____ Hourly Wage or Bi-Weekly Income | _____ Hours / Week (if hourly wage) | _____ Employer / Source of Income

Spouse Income Information

$ _____ Hourly Wage or Bi-Weekly Income | _____ Hours / Week (if hourly wage) | _____ Employer / Source of Income

Other Household Income Total

Please include the income of anyone age 18 or older who lives in the same household.

$ _____ Total Monthly or Annual Income

☐ Monthly ☐ Annual ☐ No other household income

Other Types of Income - Please check boxes for all that apply.

☐ Alimony $ _____ / month
☐ Child Support $ _____ / month
☐ Social Security $ _____ / month
☐ ADC $ _____ / month
☐ Additional Work $ _____ / month
☐ Disability $ _____ / month
☐ Pension $ _____ / month
☐ Retirement $ _____ / month
☐ Welfare Assistance $ _____ / month
☐ Unemployment $ _____ / month
☐ Other, Please Specify: _____, $ _____ / month
☐ None of the above

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Household Information

# of Family Household Members (including yourself):_____

Please list all persons to which you are legally related and providing financial support.

First Name	Last Name	Date of Birth	Relationship to Applicant
First Name	Last Name	Date of Birth	Relationship to Applicant
First Name	Last Name	Date of Birth	Relationship to Applicant
First Name	Last Name	Date of Birth	Relationship to Applicant

# of Other Household Members: _____

Please list all non-related persons age 18 or older who currently live with you.

First Name	Last Name	Date of Birth	Monthly or Annual Income
First Name	Last Name	Date of Birth	Monthly or Annual Income
First Name	Last Name	Date of Birth	Monthly or Annual Income
First Name	Last Name	Date of Birth	Monthly or Annual Income

ATTESTATION

To whom it may concern:

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.

Furthermore, I agree to inform Solvera Health if there is a significant change in my household income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Solvera Health. I hereby acknowledge that I read the foregoing disclosure and understand it.

_____

Applicant Signature Date

Solvera Staff Reviewed By: _____ Date Approved: _____