Application for Sliding Fee Discount

Name: _____ SS# _____

Address: _____ Telephone# _____

_____ Date of Birth: _____

Total Number of persons in Family/Household* _____

*** SFDS Household Member** - a person whose legal residence is in the immediate home and may be legally claimed as a dependent deduction on the parent(s) or guardian's federal income tax return. This is generally anyone who depends on the financial support of a parent or guardian and who may legally claim the dependent on their federal income tax return.

List Total Annual Income** of the above Family/Household and **ATTACH VERIFICATION**

****SFDS Household Income** – the total income that is reported as gross income on an individual, joint, head of household or married filing separate federal tax return(s). Income would otherwise include all of the gross wages, tips, social security disability, veteran payments, alimony, child support, military, unemployment, and public aid for all income earning members of the household, which would otherwise include the dependent's income.

*****SFDS Income Verification** – process by which a SFDS Applicant's income is verified for placement within the Sliding Fee Discount Schedule. The following forms of income level may be used for verification processes: (Circle)

1. Latest Income Tax Return(s) of all income earning family members. The sum of the Gross Wages on the returns will be used as annual household income.
2. Copies of at least 2 current earning statements (pay stubs, either bi-weekly or monthly), from applicable employers and government/public assistance entities, etc. The Gross Earnings of these types of proof will be annualized for proper placement into the SFDS.
3. Self Declaration of Income/Unable to Provide Documentation

Total Annual Income $_____**

Applications for discounted services will be returned if all proof of income is not attached.***

I request that Cornerstone Care determine my eligibility for the sliding scale for all services provided by Cornerstone Care. I understand that the information I submit is subject to verification by Cornerstone Care. I also understand that if the information which I submit is determined to be false, it will result in denial of the sliding scale eligibility, and I will be liable for payment in full.

I verify that the above and attached information is correct to the best of my knowledge. If I become eligible for the sliding scale and do not make the required payments, I am aware that my account, and/or the accounts of my eligible family members, will be sent to a collection agency.

APPLICANT SIGNATURE _____ DATE_____

OFFICE USE ONLY
I verify that the above information is correct to the best of my ability and I have reviewed all documents demonstrating proof of income.

STAFF SIGNATURE_____ DATE_____