Sliding Fee Schedule Application

Sliding Fee Discount Information

It is the policy of The Mountain Center Healthcare Clinic to provide essential services regardless of the patient's ability to pay. The Mountain Center offers discounts based on family size and annual income.

Please complete the following information and return 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 those services or equipment purchased from outside, including reference laboratory testing, drugs, and other such services. You must complete this form every 12 months or if your financial situation changes.

Name:		
Address:		
City:	State:	Zip:
Phone:		
Email:		

Please list all household members, including those under 18.

Relationship	Name	DOB
Self		
☐ Dependent ☐ Parent ☐ _____		
☐ Dependent ☐ Parent ☐ _____		
☐ Dependent ☐ Parent ☐ _____		
☐ Dependent ☐ Parent ☐ _____		

Source	Self	Other	Total	Per
Gross wages, salaries, tips, etc.				☐ Month ☐ Year
Income from business and self-employment				☐ Month ☐ Year
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, Veterans' payments, survivor benefits, pension or retirement income				☐ Month ☐ Year
Interests, dividends, royalties, income from rental properties, estates, and trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources				☐ Month ☐ Year
Total Income				☐ Month ☐ Year

I certify that the family size and income information shown above is correct. I understand that I may need to provide additional documentation.

Signature: _____ Date: _____

Office Use Only

Patient Name: _____

Approved Discount:

▢ 75% ▢ 50% ▢ 25% ▢ 10%

Fees Waived: (Provide reason): _____

Approved By:_____Date:_____