

SWLA CENTER FOR HEALTH SERVICES
(SWLACHS)

Sliding Fee Scale Pre- Determination Data Worksheet

Completion of this form must be accompanied by proof of eligibility for a sliding fee scale discount. **This worksheet is available to all persons without regard to race, creed, color, age, religion, country of origin, sex or sexual orientation, any disability, and ability to pay.** Patients are charged for the full fee for services until all documentation is provided and that documentation demonstrates that the patient qualifies for some percent discount of the full fee. SWLA Center for Health Service cannot provide the patient with the level of discount until all documentation is provided. **All sliding fee applications will be reviewed by the eligibility staff to determine the discounted amount according to the income and family size.**

Patient Name: _____ D.O.B. _____ Sex: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers (Home): _____ (Office/Cell): _____

Things you should bring with you: Sources of identification, proof of residency, proof of family size and forms of income verification. These items will help staff determine your eligibility.

Eligibility Determination Worksheet

Income Verification (Check all that apply, for client and household)

- \$ _____/month Current Month's Pay Stub(s) - (1) stub/monthly, (2) stubs/Bi-monthly, (4) stubs/Weekly
- \$ _____/month Employer letter, on letterhead with hourly wage and hours worked per week
- \$ _____/month Current year pension benefits letter
- \$ _____/month SSA/SSI Current year award letter
- \$ _____/month AFDC Current letter award letter
- \$ _____/month Self-employment income log (verification of current work)
- \$ _____/year W-4 and/or most recent completed tax form from current income source
- \$ _____/month unemployment insurance
- \$ _____/month child support
- \$ _____/month workman's compensation
- \$ _____/Other

Name of Family Members	D.O.B