SLIDING FEE SCALE AND INCOME VERIFICATION FORM

FORM USE:

- ☐ I am completing this form to apply for a sliding fee scale discount in the event my insurance does not cover the cost of all services I received at Unity Care NW. I will provide proof of income within the next five days in order to receive a discount on my medical, dental, pharmacy, behavioral health, lab, or imaging services received at Unity Care NW that are not covered by my health insurance.
- ☐ I am completing this form so Unity Care NW can comply with reporting requirements for its funding.

Your Full Name:	Email Address:	
Mailing Address:	Phone number:	Can we leave a detailed message at this phone number? Yes or No

1) Please list information for all members of your household <u>and</u> people included on your tax return:

FULL NAME	RELATION TO YOU	PATIENT AT UNITY CARE NW? YES	NO	DATE OF BIRTH	CURRENTLY COVERED BY HEALTH INSURANCE? YES	NO	EMPLOYED YES	NO	GROSS MONTHLY INCOME (before taxes and deductions)	SOURCE OF INCOME (ex: social security, unemployment, work, family)	WILL YOU BE CLAIMED AS A TAX DEPENDENT THIS YEAR? YES	NO
	self								$			
	spouse								$			
	dependent								$			
	dependent								$			
	dependent								$			
	dependent								$			
	dependent								$			
	dependent								$			

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In order to receive a discount on services, we will need you to provide one of the following documents to verify your income:

- ☐ Most recent year IRS 1040 personal/self-employment tax return
- ☐ Most recent employment paystubs showing income for past 30 days of income
- ☐ Most recent unemployment paystubs showing income for past 30 days
- ☐ Current year Award/Benefit Letter from other sources (L&I, Child Support, Disability, Social Security, Veteran's Benefits)
- ☐ Two months of most recent bank statements (all accounts)
- ☐ If you have **no** income, please complete Unity Care NW's self-attestation of no income (ask for this form from the receptionist)

- ☐ I decline to report household and income information that would support Unity Care NW's ability to continue to receive funding.

2) **I AGREE THAT THE ABOVE INFORMATION IS CORRECT AND ALL SOURCES OF INCOME HAVE BEEN REPORTED. I WILL REPORT ANY INCOME CHANGES AND RE-APPLY EVERY YEAR EVEN IF NO CHANGES OCCUR. FAILURE TO MEET THESE CONDITIONS MAY DISQUALIFY ME FROM FUTURE UNITY CARE NW FEE DISCOUNTS:**

Signed:_____ **Date**:_____

UCNW USE ONLY: WORKSHEET REVIEWED BY:_____ OUTCOME: _____

Initials_____: I give Unity Care NW's Enrollment Specialists permission to access income information verified through the *Washington Health Plan Finder* for the purpose of determining my discount for Unity Care NW's sliding fee scale.