SLIDING FEE DISCOUNT PROGRAM APPLICATION AND INCOME VERIFICATION FORM

Completing this form and providing proof of income may make patients eligible to receive discounts on medical, dental, behavioral health and pharmacy services at Unity Care NW that are not covered by health insurance.

Your Full Name:	Email Address:	
Mailing Address: Physical Address: (if different than mailing)	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 and 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								$			

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

- ☐ Most recent employment paystubs showing income (wages, salaries, tips and commissions) for the past 30 days
- ☐ Previous year's IRS 1040 personal/self-employment tax return showing net self-employment or business income
- ☐ Most recent unemployment paystubs showing income for past 30 days
- ☐ Current year Award/Benefit Letter from other sources (Social Security, Veteran's Benefits)
- ☐ Proof of other types of household income (alimony/spousal support, retirement and pension income, Investment and rental income, per capita distributions from tribal gaming).
- ☐ Two months of most recent bank statements - all accounts. **(Note: Not accepted if employed – provide pay stubs)**.
- ☐ If you have **no** income, please complete Unity Care NW's self-attestation of no income (ask for this form from the receptionist)

- ☐ I do not intend to apply for a sliding fee discount.
- ☐ I decline to report household and income information.

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:**_______________________________

FOR OFFICE USE ONLY:

Income source received: Type: ____________________ Amount: _________ Type: ____________________ Amount: _________

Type: ____________________ Amount: _________ Type: ____________________ Amount: _________

TOTAL HOUSEHOLD INCOME: ____________________

TOTAL NUMBER IN HOUSEHOLD: ____________________

SLIDE DISCOUNT DETERMINATION: ____________________