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 NW that are not covered by health insurance.

Patient or Name of Person Completing Form:	DOB of Patient Person Completing Form:
Mailing Address:	Phone Number: **Can we leave a detailed message at this number? YES or NO**
Physical Address (if different than mailing address):	Email Address:

Please list information for all members of your household included on your tax return below:

Relation to You	Full Name	Date of Birth	Patient at UCNW?		Currently Covered by Health Insurance?		Employed?		Gross **Monthly** Income (Before taxes and deductions)	Source of Income (Social Security, unemployment, work, family, etc.)	Will they be claimed as a tax dependent this year?	
			YES	NO	YES	NO	YES	NO			YES	NO
YOURSELF									$			
SPOUSE									$			
DEPENDENT									$			
DEPENDENT									$			
DEPENDENT									$			
DEPENDENT									$			
DEPENDENT									$			

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To accurately assess your household to receive a discount on services, you must provide one of the following documents to verify your income:

- ☐ Employment paystubs showing income (wages, salaries, tips, and commissions) from the past 30 days
- ☐ IRS 1040 personal/self-employment tax return showing gross self-employment or business income from the previous year
- ☐ Unemployment paystubs showing income from the past 30 days
- ☐ Award/Benefit Letter from other sources (Social Security, Veteran's Benefits) from the current year
- ☐ Proof of other types of household income (alimony/spousal support, retirement and pension income, investment and rental income, per capita distributions from tribal gaming)
- ☐ Bank statements from the last 60 days for all accounts – NOTE: If employed, must provide pay stubs when available
- ☐ No income, paid by cash only, or proof of income not available – please tell the Front Desk/O&E Staff when returning this form and you will be provided with another form.

By signing below, 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 have occurred. Failure to meet these conditions may disqualify me from future Unity Care NW fee discounts.

Signature: _____ **Today's Date:** _____

FOR UCNW OFFICE STAFF USE ONLY

Income Source Received:	Type:	Amount:	Type:	Amount:
	Type:	Amount:	Type:	Amount:
Total Household Income:				
Total Number in Household:				
Slide Discount Determination/Date:				