GREATER BADEN MEDICAL SERVICES, INC.
SLIDING SCALE FEE APPLICATION

Patient's Name: _____ SS#:_____

Name of Responsible Party: _____ SS#:_____

Mailing Address: _____
Street/P.O. Box City State Zip Code

List **All Household Members** (Include Responsible Party):

NAME:	DATE OF BIRTH:	EMPLOYER:
	RELATIONSHIP:	INCOME: How Often

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NAME:	DATE OF BIRTH:	EMPLOYER:
	RELATIONSHIP:	INCOME: How Often

List Sources of Income Other Than Employment Wages:

*Examples of Required Additional Income Sources–Self Employment, Disability, Social Security Child Support, Trust Funds, Social Services, Stocks, Pensions, etc.

1. _____
2. _____
3. _____

OVER

GREATER BADEN MEDICAL SERVICES, INC.
SLIDING SCALE FEE APPLICATION

Other Information: _____

_____

_____

_____

_____

I certify that all the above information is true and complete to the best of my knowledge with the understanding that any false or incomplete statement of family size and/or financial information may result in loss of eligibility for all household members listed. Explanation was provided to me by a Greater Baden Medical Services staff member regarding the sliding fee procedure and I fully understand my financial obligation of medical services and/or testing until written verification is provided for each household member listed. Written verification for each source of income is required to qualify. Acceptable forms of written verification are listed below.
I further understand that I have 2 weeks to bring in written verification of income or I will be responsible for paying the full customary fee. If I qualify for the sliding fee, it will remain in effect for 1 year unless my family income changes.

_____ _____

Applicant's Signature Date Witness Date

Acceptable Forms of Written Verification:

2-4 Current Paycheck Stubs Federal Tax Return Self-Employed Tax Return
Disability Income Alimony Document Child Support Document
Retirement/Pension Social Service Denial Trust Fund/Stock Income
Financial Letter on Company Letterhead from Employer

GBMS Staff Use Only:

Patient Refused to Fill Out Application:
Total Number of Household Members:
Total Income of Family Unit:
Fee Assigned to Patient:
Not Eligible:
Date Responsible Party Will Bring Verification Information In:
Date Sliding Scale Information Entered In System:
Date Sliding Scale Expires:
Patient or Responsible Party Received Copy:
Staff Signature: Date:

PLEASE COPY THIS PAGE FOR THE PATIENT.