MACT HEALTH BOARD, INC

Sliding Fee Scale Application

Patient Information			Today's Date: / /	
First Name:	Middle:	Last:	Home Phone #: ( ) -	
Home Address:		City:	State:	Zip:

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

NOTE: In compliance with federal regulations, in order to give you a discount on your medical services, it is necessary for MACT to obtain certain information. Your answers will be kept confidential. You must verify your income at least once per year.

A copy of your income tax return, a W-2, last month's paycheck stubs, social security checks or bank statement(s) must be provided. Your annual income and your family size will be used to calculate your discount.

Household Income

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

For Use by Finance Dept. Only
A – 20% Discount/$67 OV
B – 15% Discount/$71 OV
C – 10% Discount/$76 OV
D – 5% Discount/$80 OV
E – 0% Discount

Initials: _____

Date: ____/____/____

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws. I further agree to inform MACT Health Board if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of MACT Health Board.

I hereby acknowledge that I read and understand this disclosure.

Full Name (Print):_____

Signature: _____ Date: _____