Sliding Fee Program Application

It is the policy of Comprehensive Care of Kansas, LLC to provide services regardless of the patient's ability to pay. The Sliding Fee Schedule is based on household size and annual income. Please complete the following information to determine if you are eligible to participate in the Sliding Fee Program.

The discount will apply to all services received at this practice, but not those services or equipment that are purchased from outside, including medications and laboratory testing. This form must be completed every 12 months, or sooner if your financial situation changes.

Name: ____
Place of Employment: ____
Address (City, State, Zip): ____
Phone Number: ____
Date of Birth: ____

Please list the patient, partner or spouse, and dependents. For the purpose of this application, dependents include children and any other loved ones who live in the same residence and are assisted financially by the applicant, even if they are not claimed for tax purposes.

Name	Relationship	Date of Birth

Annual Household Income

Only include income for those who help you pay for living expenses, such as rent, utilities, and food. Do not include income for anyone under the age of 18 years, unless they are receiving child support AND they are the applicant.

Source	Self	Partner	Other	Total
Gross wages, salaries, tips, etc.				
Income from business or self -employment				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				

Interest, dividends, rents, royalties, income from estates, trusts, alimony, child support (ONLY if the applicant is the child receiving this support), consistent monetary assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.
Name: ____
Signature: ____
Date: ____

Office Use Only

Patient Name: ____

Approved Discount: ____

Approved By: ____

Date Approved: ____

Date Letter Sent to Patient: ____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year's tax return, three most recent pay stubs or other		
Insurance: Insurance cards		