SLIDING FEE ELIGIBILITY FORM

Patient Account: _____

Mainline Health Systems, Inc. Sliding Fee Program is for patients and their families to pay according to their income. The Federal Poverty Scale is used for determination of level. ***All income and family information must be updated ANNUALLY to remain on active Sliding Fee Status.*** *Please list family members that are claimed on your tax return or not living with you that are mainly supported by your income. Head of Household* ***MUST*** *be included in the list below.*

PLEASE COMPLETE THE INFORMATION BELOW

HOUSEHOLD VERIFICATION (*Please list Head of Household first)*

Name	Age	Date of Birth	SSN	Relationship to Applicant
				Head of Household

TOTAL NUMBER IN HOUSEHOLD: _____

INCOME VERIFICATION (*Please enter the ANNUAL amount)*

Type of Income	For You	Spouse	Children	Others
Gross Wages & Salaries	$	$	$	$
Social Security & Pensions	$	$	$	$
Unemployment Benefits	$	$	$	$
Veteran's Benefits	$	$	$	$
Public Assistance	$	$	$	$
Other: _____	$	$	$	$
TOTALS	**$**	**$**	**$**	**$**

SELF-ATTESTATION OF INCOME: ☐ YES ***(Valid for 1 year only; must provide documentation in Year 2)***

Do you file a tax return? ☐ YES ☐ NO

Do you have insurance? ☐ YES ☐ NO ***If YES, please present your card to the MHSI staff.***

I certify that the above information is correct to the best of my knowledge.

Patient/Responsible Party Date

MHSI Employee Date

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OFFICE USE ONLY

Total Household Income: _____ Sliding Fee Level: _____

updated 12/2022