

**LITTLE RIVERS HEALTH CARE, INC.**  
**SLIDING FEE SCALE APPLICATION**

*All sections and questions must be answered. If a section or question does not apply, write in "N/A".*

**APPLICANT'S INFORMATION**

Your Name: \_\_\_\_\_ Your Date of Birth: \_\_\_\_\_

Your Social Security #: \_\_\_\_\_ Your Telephone #: \_\_\_\_\_

Your Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Your Employment Status: (Please Circle) Employed, Unemployed, Self-Employed, Disabled, Retired, Student, Minor

Indicate type of health insurance you have: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ No Insurance

**YOUR HUSBAND/WIFE/PARTNER INFORMATION**

Husband/Wife/Partner Name: \_\_\_\_\_ His/Her Date of Birth: \_\_\_\_\_

His/Her Social Security #: \_\_\_\_\_ His/Her Phone #: \_\_\_\_\_

His/Her Employment Status: (Please Circle) Employed, Unemployed, Self-Employed, Disabled, Retired, Student, Minor

Indicate type of health insurance they have: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ No Insurance

**HOUSEHOLD MEMBER INFORMATION**

Please list and complete all columns for all household members (including wages earned in another country).

Name of Household Member	Relationship to Patient	Date of Birth	Are they Employed Yes or No	Do They Have Any Income Yes or No ***
1.				
2.				
3.				
4.				
5.				

If someone else is providing you with shelter, heat, and electricity, the value of these accommodations is considered "income" and will be calculated per household member at **\$600.00 per month** (\$7,200 annually).

**\*\*\*Please read the following statement carefully and initial here:** \_\_\_\_\_

*"I declare that the household members I listed above as not having any income do not receive income from any source"*

**To Be Completed By the Care Coordinator:**

Applicant LRHC Location: \_\_\_\_\_ Applicant LRHC Account #: \_\_\_\_\_

Other Household Members Locations: \_\_\_\_\_ Other Household Member Account #: \_\_\_\_\_

## REQUIRED DOCUMENTS TO VERIFY INCOME

Please provide a copy of your two most recent bank statements and a complete current year federal tax return including all schedules. (If you do not file please circle "NO" below).

Do you file an income tax return? YES NO If "YES" but your income has changed since filing your most recent tax return, please provide us with some documentation supporting your claim.

Do you have any bank accounts? YES NO If "NO" how do you cash checks and pay bills.

Each person you listed as a household member, who would like to be included in this application for a discount must provide the following documentation:

TYPE OF INCOME	WHAT IS REQUIRED FOR VERIFICATION	TYPE OF INCOME	WHAT IS REQUIRED FOR VERIFICATION
*Employer Paid Wages	Three (3) most recent pay stubs	Pension	Statement or Proof of Bank Deposit
Self-Employed	Two most recent bank statements & Complete Federal tax return with all schedules	Annuity/IRA	Statement or Proof of Bank Deposit
Social Security	Current Year Benefit Letter	Unemployment	Benefit Letter
Disability	Current Year Benefit Letter	Worker's Comp	Benefit Letter
401k Withdrawal/Distribution	Form 1099-R, Proof of Bank Deposit or Proof of Rollover	Child Support	Court Order or Signed Letter from Payor
Dividend Income	Form 1099-DIV or Proof of Bank Deposit	Alimony	Court Order or Signed Letter from Payor

\*Note: If pay stubs are not provided by the employer, a signed earnings statement from the employer will be accepted. It must show dates of pay period, gross pay, deductions, and net pay.

## ADDITIONAL INFORMATION

- 1.) Do you pay child support or alimony? ☐ Yes ☐ No If yes, how much: \$\_\_\_\_\_ per \_\_\_\_\_.  
(Please attach a copy of the court order or signed letter from recipient).
- 2.) I pay for my housing as follows: ☐ I own my home ☐ I rent my home ☐ I do not pay for housing ☐ My employer provides free housing
- 3.) If you are not paying for housing, who provides you with housing, food & utilities \_\_\_\_\_

## APPLICANT AGREEMENT

I have reviewed this application with my care coordinator. All sections are complete and all required documents are attached. I understand that discounts will not be approved if any requested information is missing.

I certify that the household member information, including all incomes received, is true to the best of my knowledge and that all supporting documentation is also complete and true to the best of my knowledge. I understand that a false answer to any part of the application may jeopardize my status with LRHC.

If I am approved for the LRHC Sliding Fee Scale, I agree to tell LRHC of any changes in circumstances, including changes to household size, household income, health insurance coverage, deductions, etc. as soon as they happen.

Applicant Signature\_\_\_\_\_

Date\_\_\_\_\_