Sliding Fee Discount Application

To meet the requirements for our sliding fee scale (discounted services), we require the following per wage earner:

1) Proof of income can be one of the following:
   - Three (3) current consecutive pay stubs.
   - Last year's tax return (1040) or W-2 form.
   - A letter from employer stating hours worked and hourly wage, preferably on company letterhead. Must have employers name and phone number.
   - SSDI/Unemployment Award letters or Stubs (3 consecutive).
2) Proof of residency (utility bill).
3) Identification (photo ID).

SLIDE DISCOUNT EXTENDS TO FAMILY WHO LIVE IN THE SAME HOUSEHOLD ONLY!

Head of Household: _____ SSN: _____

Mailing or Physical Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (home): _____ Telephone (work): _____

Monthly household income: $_____ or Annual household income $_____

Size of family (including yourself) _____ (please list all family members below, using the back of this contract if necessary; if included family member has medical insurance, please make note in the insurance column, this will not have an effect on the status of uninsured.)

NAME	DATE OF BIRTH	INSURANCE

It is the policy of El Pueblo Health Services Inc. to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

I certify that the family size and income information shown above is correct:

Signature: _____ Date: _____

Telephone – 505-867-2324 Fax – 505-867-3511