Lemhi Valley Sliding Fee Scale Form

Note: To comply with federal regulations and to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year with yearly income tax return, a copy of W-2 form, most recent paystub, or copy of social security or other check.

Client Information				Today's Date
First Name	M.I.	Last		
Home Address		City	State	Zip
Mailing Address (if different)		City	State	Zip
Date of Birth	Social Security #	Home Phone	Mobile Phone	
Marital Status: ☐ Single ☐ In a Relationship ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			**Do you have insurance?** ☐ Yes ☐ No	

Household Size

Name	Relationship	Date of Birth	Social Security #

Household Income (*Please provide verifying documentation.*)

Person	Amount	Frequency (circle one)	Employer
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	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	$

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 Law which may include fines and imprisonment. I further agree to inform Lemhi Valley Social Services if there is a significant change in my income. If acceptance of the sliding fee program is obtained under this application, I will comply with all the rules and regulations of Lemhi Valley Social Services. I hereby acknowledge that I have read the forgoing disclosure and understand it.

Name	
Signature	Date