FOR AMERICAN FORK ONLY

NUMINUS

Sliding Fee Discount Application

It is the policy of Numinus to provide essential services regardless of the patient's ability to pay. Numinus offers discounts based on family size and annual income alone.

The discount will apply to services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, and other such services. Other exclusions will be detailed in our Sliding Fee Policy.

Please complete the following information and return it to our staff to determine if you or members of your family are eligible for a discount. Your answers will be kept on file and in strict confidence. You must complete this form every 12 months or if your financial situation changes.

Patient Information		**Today's Date:**	
First Name:	Middle Name:	Last Name(s):	
Home Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:	Email Address:	
Date of Birth:	Social Security Number:	Do you have insurance?	

Household Members		**Employment Income**		
Name (List all household members, including those under age 18.)	**Date of Birth**	**Amount**	**Frequency** (Per week, per month, or year)	**Employer**

Other Income	You	Spouse/ Partner	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Unemployment compensation, workers compensation, Supplemental Security Income, veteran's payments, survivor benefits, etc.					
Interest; dividends; royalties; income from rental properties; estates, and trusts; assistance from outside the household					
Church assistance					
Other					
Totals					

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

Print Name

Signature

Date

OFFICE USE ONLY

Patient Names:		**MRN Numbers:**
Verified ID & Address?	Driver's License, utility bill, employment ID, etc	
Verified Income?	Tax return, W-2, 3 recent check stubs, other	
Approved % of Poverty Level:		
Approved by:		**Date:**