



IF YOU HAVE ANY QUESTIONS CONCERNING THIS APPLICATION, PLEASE DIRECT YOUR QUESTIONS TO THE PATIENT ACCOUNTS REPRESENTATIVE AT 360-452-8086 ext. 2858.

Sliding Fee Program Application

Today's Date: ____/____/____ Guarantor #: _____
 Guarantor Name: _____ Date of Birth: ____/____/____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone Number: (____) _____ - _____ [] Home [] Cell [] Message phone

Employment Status:

[] Employed (Date of Hire _____) [] Unemployed (How long? _____)
 [] Self-employed [] Student [] Disabled [] Retired [] Other (_____)

Household Information:

Total Family Members _____	Include everyone related to you by birth, marriage or adoption that live together.				
Name	Date of Birth	Relationship to Guarantor	Receiving Income?	Source of Income (if any)	Total GROSS Monthly Income
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		
			Y / N		

****All adult family members' income must be disclosed. Sources of income include, but are not limited to:**

- Wages
- Unemployment
- Self-Employment
- Worker's Compensation
- Rental Income
- Disability
- Social Security
- Child Support
- Spousal Support
- Work Study
- Pension
- Retirement Account Distributions

Please provide **all** of the following documents to assist in the determination of eligibility. **Please indicate attached, not applicable or reason unable to provide.**

Proof of income for each household member:

- Pay stubs for the 3 month period prior to application.
 Attached **not applicable**
 Unable to provide because: _____
- Letters approving/denying unemployment compensation.
 Attached **not applicable**
 Unable to provide because: _____
- Documents showing acceptance /denying eligibility for Medicaid and/or medical coverage through the Washington Health Benefit Exchange system.
 Attached **not applicable**
 Unable to provide because: _____
- Proof of Social Security Benefits and/or Pension payments, if applicable.
 Attached **not applicable**
 Unable to provide because: _____
- All Checking and Savings Statements for 3 months prior to application.
 Attached **not applicable**
 Unable to provide because: _____
- Other sources of income: _____ (Source)
 Attached **not applicable**
 Unable to provide because: _____

Certain expenses / deductions can be considered. Do you pay any of the following? If yes, please indicate amount per month and attach supporting documentation.

- Do you pay monthly alimony? _____/mo.
- Have monthly student loans? _____/mo.
- Pay monthly child support? _____/mo.

****Please attach appropriate documents to support.**

I, THE APPLICANT FOR THE SLIDING FEE PROGRAM AFFIRM, THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AGREE TO PROVIDE ANY ADDITIONAL INFORMATION AS REQUESTED IN ORDER TO DETERMINE ELIGIBILITY.

Signature: _____ Date: ____/____/____

Form Approved by: BJB 12 / 2 / 2019 

Received date _____ Account # _____