It is the College Skyline Center, LLC policy to provide services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. Please complete the following information and return to the office staff to determine if you or members of your family are eligible for a sliding scale fee discount.

The discount only applies to all services received from your treatment provider at CSC, LLC. As financial situations can change, the discount will only be honored for six months, after which the patient can/must reapply. If your financial situation drastically changes, another application for adjustment may be considered before the six-month update.

Patient's Name: Phone #:

Head of Household: Date of Birth/Age:

Services Desired/Brief Explanation:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Member of Household** | | | | Date of Birth/Age | | | |
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| **Income Sources** | Self | | Spouse | | Other | | Total |
| Gross wages, salary, tips, etc. |  | |  | |  | |  |
| Social Security, pension, annuity, and veterans benefits |  | |  | |  | |  |
| Alimony, child support, military family allotments |  | |  | |  | |  |
| Self-Employment Income |  | |  | |  | |  |
| Rent, interest, dividends, and other |  | |  | |  | |  |
| Total Income |  | |  | |  | |  |
| **Verification Checklist** **(have copies)** | | Yes | | | | No | |
| Identification (driver's license, birth certificate, employment ID card, Social Security card, etc.) | |  | | | |  | |
| Income: Prior year tax return, three most recent pay stubs, or other | |  | | | |  | |
| Medicaid: Application made or evidence of rejection. | |  | | | |  | |

I certify that the information shown above is correct and understand verification is required for approval

Name (Print): Signature/Date:

**Office Use Only: APPLICATION APPROVED BY: EFFECTIVE TO HOURLY FEE:**