New Patient Self Attestation Form

Pt Name: ____

DOB: ____

Patient #: ____

Date of Service: ____

How We Determine Your Sliding Fee Discount Program Level

A patient's Sliding Fee Discount Level is based on the number of people in their household and their total adjusted annual gross income (income before taxes)

Household Size	Sliding Fee Discount Program Level					
	A	B	C	D	E	F
1	Below $14,580	$14,581 to $18,225	$18,226 to $21,870	$21,871 to $25,515	$25,516 to $29,160	Above $29,161
2	Below $19,720	$19,721 to $24,650	$24,651 to $29,580	$29,581 to $34,510	$34,511 to $39,441	Above $39,441
3	Below $24,860	$24,861 to $31,075	$31,076 to $37,290	$37,291 to $43,500	$43,506 to $49,720	Above $49,721
4	Below $30,000	$30,001 to $37,500	$37,501 to $45,000	$45,001 to $52,500	$52,501 to $60,000	Above $60,001
5	Below $35,140	$35,141 to $43,925	$43,926 to $52,710	$52,711 to $61,495	$61,496 to $70,280	Above $70,281
6	Below $40,280	$40,281 to $50,350	$50,351 to $60,420	$60,421 to $70,490	$70,491 to $80,560	Above $80,561
For each add'l person	Add $5,140	Add $6,425	Add $7,710	Add $8,995	Add $10,280	

I certify that my **annual** gross household income is $__________________.

I acknowledge that I must provide the requested proof of income within ten (10) days of today's visit to qualify for the Sliding Fee Discount Program or I may be charged the full cost for today's visit.

______________________________________ ______________________

Patient (or Guardian) Signature *Date*

- When calculating a patient's income, we consider: For annual income calculations: tax returns (personal or business if self-employed); Social Security Income or Social Security Disability Income annual benefits letters; Veterans Administration/Affairs benefits letters; W-2's.
- For monthly incomes: paystubs (two consecutive); three months of business ledger for self-employed, child support letters and/or bank statements; SNAP notices; unemployment benefit letters; Foster Care income letters; SSI or SSDI bank statements.