# Sliding Fee Scale Discount Application

Household Members: (Name and DOB) Date:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | DOB: | Name: | DOB: |
| Name: | DOB: | Name: | DOB: |
| Name: | DOB: | Name: | DOB: |
| Name: | DOB: | Name: | DOB: |

## If you are uninsured: Your Panda Pediatrics at Heartland services may be discounted on the information provided here.

If you are insured: Based on your income, you may qualify for discounted copays and other out of pocket expenses. Your out-of- pocket expenses for Panda Pediatrics at Heartland will be based on the information provided here.

If you do not wish to apply for discounts based on your income, please check here:

* **I decline to apply for the sliding fee scale. By declining, I acknowledge I will be responsible for the full fee of any services not covered by insurance.**
* **I have not provided proof of income to support my sliding fee application. I acknowledge that I will be charged full fee until I provide proof of income.**

Name:

# If wanting to apply for discounts, CONTINUE

Signature:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Source Father | | | Mother | | Other Household Members | |
|  | Amount | Frequency  (wk,mo,yr) | Amount | Frequency  (wk,mo,yr) | Amount | Frequency  (wk,mo,yr) |
| Gross wages, salaries, tips, etc. | $ |  | $ |  | $ |  |
| Income from business, self-employment,  dependents | $ |  | $ |  | $ |  |
| Unemployment compensation, workers’  compensation, Social Security, disability income, public assistance | $ |  | $ |  | $ |  |
| Child support, alimony, interest, dividends, rent, royalties, income from estates, trusts,  educational assistance and other misc. sources | $ |  | $ |  | $ |  |
| **Total Income** | **$** |  | **$** |  | **$** |  |

Total Annual Household Income: $ How many people are supported on this Income?

I understand that if I provide false information, I will be disqualified from the program and all charges will be due in full immediately. I understand I will be required to submit documentation of proof of income (if available.) By signing this form, I certify under penalty of perjury under the laws of the State of Kansas the information I am providing is true and correct.

Name: Signature:

Presumptive Eligibility (30 days)

Initials of Heartland PSR: Verified by:

POI Collected (1 year)

SELF-DECLARE

Bi-monthly (Twice per month) x 24

Weekly x 52

Frequency Calculations Monthly x 12

Every two weeks x 26

Sliding Fee Scale: A B C D E

**FOR OFFICE USE ONLY**