

### NATIONAL PEDIATRIC CENTER

# Discounted/Sliding Fee Application and Information

It is the policy of National Pediatric Center to provide essential services regardless of the patient’s ability to pay. National Pediatric Center offers discounts based on family annual income and size.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

Please inquire at the front desk if you have any questions or concerns.

|  |  |
| --- | --- |
| NAME OF HEAD OF HOUSEHOLD | **PLACE OF EMPLOYMENT** |
| **STREET** | **CITY** | **STATE** | **ZIP** | **PHONE** |

**Please list spouse and dependents under the age of 18.**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **DATE OF BIRTH** | **NAME** | **DATE OF BIRTH** |
| SELF |  | **DEPENDENT** |  |
| **SPOUSE** |  | **DEPENDENT** |  |
| DEPENDENT |  | **DEPENDENT** |  |
| **DEPENDENT** |  | **DEPENDENT** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SOURCE** | **SELF** | **SPOUSE** | **OTHER** | **TOTAL** |
| Gross wages, salaries, tips, etc. |  |  |  |  |
| Income from business, self-employment, and dependents |  |  |  |  |
| Unemployment compensation, workers’ compensation, Social Security, Supplemental Security Income, public assistance, veterans’ payments, survivor benefits, pension, or retirement |  |  |  |  |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources |  |  |  |  |
| **Total Income** |  |  |  |  |

**NOTE:** Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

**I certify that the family size and income information shown above is correct.**

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|  |

 **Name**

**(Print)**

|  |
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|  |

 **Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OFFICE USE ONLY**

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approved Discount:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approved by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Approved:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **Verification Checklist** | **Yes** | **No** |
| Identification/ Address: Driver’s license, utility bill, employment ID |  |  |
| Income: Prior year tax return, three most recent pay stubs, or other |  |  |