Sliding Fee Discount Information

It is the policy of HHCSS, LLC to provide essential services regardless of the patient's ability to pay. HHCSS, LLC offers discounts based on family size and annual income.

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 office, but not those services or equipment purchased from outside. You must complete this form every 12 months or if your financial situation changes.

Name:				
Street:	**City:**	**State:**	**Zip:**	**Phone:**

Please list all household members, including those under age 18.

	Name	**Date of Birth**
Self		
Other		
Other		
Other		
Other		
Other		

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
Total Income			

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

Name (Print):_____

Signature:_____

Date:_____

Office Use Only

Patient Name:
Approved Discount:
Approved by:
Date Approved:

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

Self-declaration of income may also be used.