Whole Health Clinical Group
Sliding Fee Discount Application

It is the policy of WHCG to provide essential services regardless of your ability to pay. WHCG 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. If eligible, the discount will apply to all services received at this clinic, but not those services purchased from outside, including laboratory testing, drugs, and other such services. .

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		

Source of Income	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: _____

Signature: _____ **Date:** _____

For Office Use Only

Client 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		
Insurance Card(s)		
Medicaid: Application made or evidence of denial/rejection		
Other:_____		

Self-declaration of income may also be used.