Wheeler | COMMUNITY | HEALTH | CARE

SLIDING SCALE APPLICATION

_____ _____ _____

Print Client Name *Date of Birth* *Client Number*

Income Verification:

Are you employed? □ Yes □ No

Are you collecting any unemployment benefits? □ Yes □ No □ N/A

Verification of all income received from an employer or from the CT Department of Labor must be attached to this form to process your application.

Gross Family Income Determination:

Income Source	Hourly Pay Rate	# of Hours Worked Weekly	Weekly Pay Amount	Monthly Pay Amount (weekly pay x 4.3)	Total Income
Self-Income	$ /hr.	hrs.	$	$	**$**
Spouse/Significant Other's Income	$ /hr.	hrs.	$	$	**$**
Other Weekly or Monthly Income Source: _____			$	$	**$**
				Gross Monthly Income Total	**$**
				Gross Annual Income Total (monthly x 12)	**$**
				Persons in Household	
				INTERNAL USE: Sliding Fee Scale Category Determination (refer to Sliding Fee Scale)	

Service Type	Fee	Service Type	Fee
Intake	$	Medical Office Visit – New	$
Outpatient Services > 30 min	$	Medical Office Visit – Established	$
Outpatient Services < 30 min	$	Preventative Office Visit	$
Intensive Outpatient (IOP)	$	Chiropractic Services	$
Behavioral Health Group	$	Nutrition Services	$
Psychiatric Evaluation	$	Dental – Diagnostic & Preventive	$
Med Management	$	Dental – Specialty	$
Transcranial Magnetic Stimulation (TMS) Therapy	$	Dental – Complex Services	$

Attestation:

By signing below, I attest to the fact that the information which I have provided above is truthful and accurate to the best of my knowledge. I acknowledge I am obligated to contact Wheeler Clinic if my income or household status changes.

Patient/Client Signature: _____ Date of Signature: _____

Internal Use Only: **Effective Date of Fee: _____**

Reviewing Staff Name (print):_____ Date:_____