Name:
Address:
City, State:
Zip Code:
Telephone:
Social Security #:
Date of Birth:
Chart Number:

DETROIT RECOVERY PROJECT
123 MAIN STREET
DETROIT, MI

SLIDING FEE ELIGIBILITY FORM

It is necessary for us to ask personal questions in order to give you a discount on our medical/dental fees. This information will be kept on file in our center in strict confidence you must verify your income at least annually. A copy of your two (2) current pay stubs (within the past 3 months), disability check stub, SSI check stub, current unemployment check stub or statement, child support check stub, court ordered settlements and other written verifiable income statement will be sufficient proof. Your annual income will be used to calculate the level of your payment.

Today's Date: _____ Number of people living in your home? _____

What is your marital status? ☐ Married ☐ Widow(er) ☐ Single ☐ Divorced ☐ Separated

Amount of Household Income?

You	Your Spouse	Your Children	Other Person	Total Family Income

Place of Employment?

You	Your Spouse	Your Children	Other Person

Do you receive any income from any of the following sources?
(check all that apply)

Sources	Yes	No
Pay Stub		
Disability/SSI Income		
Unemployment Income		
Retirement Pension		
Child Support		
Other (Specify)		

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes, list below ☐ No ☐

Give Names and relationship of all individuals living in the household.

Name	Relationship

I declare the above information is true and have given the Health Center permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Signature:	Date:	*Clinic Purpose Only* Income Code: