OFFICE *of* PRACTICE
College of Nursing
EAST TENNESSEE STATE UNIVERSITY

SLIDING FEE DISCOUNT APPLICATION

It is the policy of ETSU College of Nursing health centers is to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a discount.

Discounts apply to services within the health center, and will not be applied to services purchased from outside, including **reference laboratory testing, drugs, hearing aids, and other such services. *** Discounts apply only to current, not future services. *Additional charges may apply for these services.

If you do not wish to apply for the Sliding Fee Scale, please check the box below, sign and date. If you do wish to apply, then skip to the next section and sign at the end of the document.

☐ I do not wish to apply for the Sliding Fee Scale discount program at this time, and I understand I may apply at any time.

Signature: _____ Date: _____

Name of Head of Household	DOB	Phone Number	
Street	City	State	Zip code

Total Family Size_____ **Please list ALL dependents**

Name	Date of Birth	Name	Date of Birth
Dependent		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual/Monthly Household Income: You may report your income in an Annual or Monthly amount. Please circle which option you are reporting below.

Source of Income (Annual or Monthly)	Self	Spouse	Other	Total Amount
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 income, 1040 tax form				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Annual/Monthly Gross Income *Gross income is before taxes and deductions				

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

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

I understand this information must be provided within 3 business days of the date of visit to qualify for the discounted fee. If this information is not received, then I understand I will be responsible for the full fee for the visit.

Name (Print):	**Signature:**
Date:	

******************For office use only****************************For office use only********************

Checklist	(✓)	Awaiting Proof of Income	(✓)
Verified Monthly Income: Total Amount:	☐	Proof of income Requested: Date:	☐
Number in Household: Total:	☐	Income Requirement Discussed with Patient: Date:	☐
Proof of Income Received: Type:	☐	Notes:	
Sliding Fee Discussed with Patient: Sliding Scale Category:	☐		
Recertification Date:	☐	Staff Signature:	Date: