SLIDING FEE DISCOUNT PROGRAM APPLICATION

The Sliding Fee Discount Program may reduce your cost for services at all Grand Peaks facilities!

**Even if you have insurance, you may qualify for discounts, which may reduce your out of pocket costs!*

MEDICAL, DENTAL & BEHAVIORAL HEALTH DISCOUNTS	***PHARMACY DISCOUNTS***
• Discounts are based on family/household size & income • Calculation is based on federal guidelines	• All patients are eligible for discounted prescription costs • You must provide proof of income to qualify

TO QUALIFY FOR DISCOUNTS YOU MUST:

1. **Apply for the discount program by completing the ENTIRE application/form and sign below**
2. **Provide Grand Peaks proof of all gross income within 3 BUSINESS WEEKDAYS after the date of this application.**

Please note:

- **Gross Income must be provided for all members of the family/household.**
  - Gross income: All income before taxes and deductions are with-held and all types of Social Security income.
  - Family/household: Includes a tax filer, spouse, significant other and dependents living in the household, as well as dependents defined by the IRS.
  - Types of income that may be provided to Grand Peaks:
    - 2 Pay-stubs from those working in the household
    - **OR** Disability/Social Security award letter or a payment statement
    - **OR** Most recent annual Federal Income Tax Return (Form 1040)
    - **OR** a letter from your employer stating your wages (or a completed *Employment Verification Form*)
    - **OR** a signed letter from someone (not a family member) stating your living situation/income
- **Medicaid patients:** You must complete this application, however due to eligibility requirements that you have met to obtain Medicaid, additional proof of income is not needed.
- **Medicare patients:** We DO require proof of income to verify discount eligibility.

TAXABLE HOUSEHOLD INFORMATION (only need to fill out income type, weekly, monthly or annual)

FAMILY / HOUSEHOLD MEMBERS' NAME(S)	***DATE OF BIRTH***	***WEEKLY INCOME***	***MONTHLY INCOME***	***ANNUAL INCOME***
Head of Household:				
Spouse/Partner:				
Child/Other:				
Child/Other:				
Child/Other:				
Child/Other:				
Child/Other:				
Child/Other:				
Total calculated Income:		$	$	$
Total number of people in the family/household (Working and Non-Working):				

TO COMPLETE YOUR APPLICATION FOR DISCOUNTS, PLEASE READ AND SIGN BELOW:

I understand the following:

- This application is valid for ONE YEAR, unless there is a change in income (documentation required).
- I must re-apply ANNUALLY and provide documentation in order to continue to receive discounted services.
- A Sliding scale may change based on taxable household size and income.
- A payment is due and will be asked for/collected at the time of service.

To the best of my knowledge, the above information is true and correct. I agree to inform Grand Peaks facilities of any changes in my household size, employment or financial status. If the above information proves to be incorrect, the discount will be terminated.

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Signature Patient/Authorized Representative *Printed Name* *Date*

****IF YOU DO NOT WISH TO RECEIVE ANY DISCOUNTED SERVICES OR PROVIDE INCOME INFO, PLEASE SIGN:***

*I DO NOT wish to provide Grand Peaks with my income. I understand I will receive no discounts and be charged **full fees** for all services, including pharmacy/prescriptions, for each visit.*

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Signature Patient/Authorized Representative *Printed Name* *Date*