Self-Attestation Form Sliding Fee Discount Program

Westminster Rescue Mission offers a sliding fee discount program for patients; the discount is based on family size and income. **Patients must supply proof of income within 5 business days.** Re-verification of income is required based on the Income Verification Eligibility Period, or earlier if your eligibility changes. Documentation of proof of income is subject to audit review for accuracy. The discount will apply to services listed on the Sliding Fee Discount Program Information Sheet. Discounts will only apply to services received after the date on this form. Falsified documentation is subject to penalty.

Patient's Name:_____ **DOB:**_____

Family size is defined as a group of two (2) people or more (one of whom is head of the family) related by birth, marriage or adoption and residing together. The household size will be limited to immediate family; spouse, partner, children, and dependents. Dependents must be age 19 or younger.

Circle One: 1 2 3 4 5 6 7 8 9 Other:_____

Family Member Name	Date of Birth

Total Family Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, veteran's benefits				
Alimony, child support, military family allotments				
Income from business, self-employment, dependents				
Unemployment, worker compensation, strike benefits, etc.				
Rent, interest, dividend, royalty, other income				
***Total Monthly Family Income**				

I certify that the information shown above is correct and understand verification is required for approval. I agree to notify the health center if there are any changes in my family income or size. Failure to report any changes may result in dismissal from the Sliding Fee Scale and my account will be adjusted as such. I agree to pay any outstanding balances and understand that payment plans are available to me.

_____ _____

Name (Print) Signature/Date

_____ _____

Completed By Expiration Date