PO Box 2688 Elko, NV 89801 | Phone: 775-738-4158 | Fax: 775-778-9501

Date: _____/_____/_____

Consumer's Name: ______________________________

Greetings!

We appreciate the opportunity to provide you with health care services. We understand that sometimes cost can become a deterrent to getting the care that is needed. We offer a sliding fee scale to those who qualify for this assistance. In order for us to assist you with this we must ask questions and require proof regarding your income, household size, and address.

The sliding fee scale is based on the total household size and income. In order to qualify for the sliding fee scale, you must complete the application provide the following:

1. **CURRENT Government issued identification care of the head of the household.**
   a. Nevada Driver License (current)
   b. Nevada Issued Identification Card (current)
   c. Military ID (current)
   d. Consular ID (current)
   e. Passport (current)

*The following are **NOT** considered as appropriate identification: Expired ID, School ID, Birth Certificate*

2. **Proof of address with the name and address of the head of the household. See the following list of examples:**
   a. Utility Bill (Natural Gas, Electricity, Water, Garbage, Home Phone)
   b. Rent Receipt
   c. Lease or Rental Agreement
   d. Car registration or insurance
   e. Personal Property Tax

*The following are **NOT** considered proof of address: Cell phone bills, bank statements, credit card statements, hospital statements.*

3. **Proof of income (all incomes). The following may be used to prove gross annual income (calculated from the past two months):**
   a. Paycheck Stubs (the last TWO months)
   b. Social Security Determination or Disability Letter
   c. Unemployment Determination Letter
   d. Retirement/Pension Benefits Letter (or deposit stubs)
   e. Trust Distribution Letter
   f. Self-Certification Letter (If not working or receiving income)
   g. Most Current Income Tax Return

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Sliding Fee Discount Application

It is the policy of **Vitality Unlimited** to provide essential services regardless of the patient's ability to pay and will not discriminate on the basis of an individual's race, color, sex, national origin, disability, religion, age, sexual orientation or gender identity. Discounts are offered based on family size and annual income. Please complete the following information and return it so that we may determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, emergency medical visits and other such services. This form must be completed every 12 months or if your financial situation changes.

Name of HoH: ______________________________ Employer: ___________________

____

Street City State Zip

Phone Number: _________________________ Email: _________________________

Please list spouse and dependents under age 18

Name	Date of Birth		Name	Date of Birth
SELF			DEPENDENT	
SPOUSE			DEPENDENT	
DEPENDENT			DEPENDENT	
DEPENDENT			DEPENDENT	

Annual Household Income

Source	Self	Spouse	Other	Total
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, Pensions or Retirement Income.				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.				
Total Income				

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Sliding Fee Discount Application

NOTE: Please provide the following items:

- **Proof of Identity**
- **Proof of Income**
- **Proof of Address**

***All household income must be reported.**

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

Name (Print): ____

Signature: ________________________________ **Date:** ________________________

FOR OFFICE USE ONLY

*Please attach copies of **ALL** required documents and fax to the Business Office at 775-778-9501 or email them to the appropriate accounting/business personnel. Scan form into Patient Documents in eCW. **Forward the original document to the Business Office attention CFO**.

OFFICE USE ONLY

Submitted by: ____________________________________ Date: ____________________
Name of Staff Member

VERIFICATION CHECKLIST

Identification/Address: Driver's license, employment ID or other	☐ Yes	☐ No
Income: Prior year tax return, three most recent pay stubs, or other	☐ Yes	☐ No
Address: Insurance Cards, utility bill,	☐ Yes	☐ No

Explanation of any issues with submitted verification documentation:

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Reviewed by: ____________________________________ Date: ____________________