



P.O. Box 2580, Elko, NV, 89803 | Phone: 775-738-4158 | Fax: 775-778-9501

Date: _____

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. To qualify, you must complete the application and provide the following:

1. Current government issued identification card of the head of the household.

- a. Nevada driver's license
- b. Nevada issued identification card
- c. Military identification card
- d. Consular identification card
- e. Passport

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 (2) months)
- b. Social Security determination or disability letter
- c. Unemployment determination letter
- d. Retirement or 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 client'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 we can determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at our clinics, but not those services that are purchased from outside, including but not limited to laboratory testing, medications, and emergency medical visits, and X-ray interpretation by a consulting radiologist. This form must be completed every 12 months or if your financial situation changes.

Head of household: _____ Employer: _____

_____ Address _____ City _____ State _____ Zip _____

Phone Number: _____ Email: _____

Please list self, spouse and dependents younger than 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, 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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Please provide the following items:

Proof of identity

Proof of income (All household income must be reported.)

Proof of address

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

Print Name: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY

*Please attach copies of ALL required documents and fax them to the Business Office at 775-778-9501 or email them to the appropriate accounting/business personnel. Scan form into client's electronic health record. **Forward the original document to the Business Office attention CFO.**

Submitted by: _____ Date: _____

Name of staff member

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:

Reviewed by: _____ Date: _____