

**HEURISTIC HEALING INC.**

**1222 W. 95th St**

**CHICAGO, ILLINOIS 60643**

**PHONE: 773-238-5555**

**FAX: 773-238-5533**

**HH INC & HQ2 DISCOUNT PROGRAM PATIENT APPLICATION**

**Sliding Fee Discount Information**

It is the policy of HH INC & HQ2 to provide essential services regardless of the patient’s ability to pay. HH INC & HQ2 offers discounts based on family size and annual income.

Please complete the following information and return to the front desk to 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 purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

NAME :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP \_\_\_\_\_\_\_\_\_\_\_

PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all household members, including those under age 18.**

|  |  |  |
| --- | --- | --- |
| Family Member | Name | Date of Birth |
| Self |  |  |
| Other |  |  |
| Other |  |  |
| Other |  |  |
| Other |  |  |
| Other |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Source** | **Self** | **Other** | **Total** |
| **Gross wages, salaries, tips, etc.** |  |  |  |
| **Income from business and self-employment** |  |  |  |
| **Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income** |  |  |  |
| **Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources** |  |  |  |
| **Total** |  |  |  |

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

|  |  |  |
| --- | --- | --- |
| Name (Print) |  | Date |
| Signature |  |  |

**OFFICE USE ONLY**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approved Discount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Verification Checklist** | **Yes** | **No** |
| **Identification/Address: Driver’s license, utility bill, employment identification, or other**  |  |  |
| **Income: Prior year tax return, three most recent pay stubs, or other**  |  |  |