Aspire Network

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# **SLIDING FEE APPLICATION:** Please help us determine if you are eligible for discounted fees for services not covered by insurance or if you have difficulties paying for your deductible. The information you provide will be kept confidential and only accessed by the administrator responsible for billing.

**PATIENT INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Last Name: | | | First Name: | | | |
| Date of Birth: | | Gender: M  F | |  | | |
| Phone Number: | | |  | | | |
| Address: | | | | | | |
| Marital Status: | Single | Married | Divorced | | Separated | Widow(er) |
| Number of people living in your home: | | | | | | |
| What is your monthly household income; single or combined? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Based on your income bracket and household size, you agree to pay, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

I hereby affirm that to the best of my knowledge that the information provided on this application is true and correct. I understand that any misleading or falsified information and/or omissions may disqualify from participating in the sliding fee scale program.

I further agree to inform **Aspire Network** of any significant changes in my income.

**I agree to make payments: (Select one)**

□ 1 x weekly

□ Bimonthly

□ 1 x monthly

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client/Parent/Guardian**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Aspire Network Staff**