

Sliding Fee Discount Application

It is the policy of Comprehend Inc. to provide essential services regardless of an individual's ability to pay. Individuals are strongly encouraged to apply for any healthcare coverage for which they may be eligible. Comprehend staff members will provide assistance with the application process.

Comprehend Inc. offers a sliding fee schedule for clients who qualify. Please complete the the following application and return it to the front desk staffto determine if you or members of your family are eligible for a discount. This form must be completed at least annually or any time there has been a change in your financial situation or coverage status.

Patient Name				
Name of Head of Household				
Street Address	City	State	Zip	Phone

Please list all household residents

Name	Relationship	Dependent Status Y or No	Age	Monetary Contribution Y or N



Total Number	in household	
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Annual Household Income

Source	Self	Spouse	Other	Total
Gross Wages, salaries, tips, etc.				
Income from business, self-employment, and all other contributors in the household				
Unemployment compensation, workers compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement benefits				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				
NOTE: Copies of tax returns, paystubs, &/or other support Documentation is due within seven (7) days of the date. I certify that the family size and income correct, as evidenced by my initials.	te of application.		bmitted before any disc	count can be applied Client Initials
I understand that any discounted fees are base to Comprehend. I agree to report any changes i occurs . I further understand that any awarded misrepresentation and/or material misstatemen	in my income ai fee discounts n	nd/or household : nay be withdrawn	size at the time th	e change
Name (Print)			ate	
Signature				



Insurance: Insurance Cards

Office Use Only

Patient Name:		
Approved Discount:		
Approved By: Date Approved:	:	
Verification Checklist	Yes	No
Identification/Address: Drivers License, utility bill, employment id, or other		
Income: Prior year tax return, three most recent pay stubs, or other		