

## Sliding Fee Discount Application



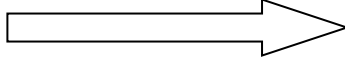
Total Number in household \_\_\_\_\_

**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				
<b>Total Income</b>				

**NOTE:** Copies of tax returns, paystubs, &/or other supporting documents verifying income must be submitted before any discount can be applied  
Documentation is due within seven (7) days of the date of application.

I certify that the family size and income information shown above is correct, as evidenced by my initials.



**Client Initials**

I understand that any discounted fees are based upon the accuracy of the eligibility information I have provided to Comprehend. I agree to report any changes in my income and/or household size at the time the change occurs . I further understand that any awarded fee discounts may be withdrawn upon the discovery of any false misrepresentation and/or material misstatement of any of my eligibility criteria.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature



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		
Insurance: Insurance Cards		