Sawtooth Mountain Clinic

Together Through Life • A 501(c)(3) Nonprofit

Sliding Fee Scale Application

Patient Information		**Today's Date: / /**		
First Name:	Middle Initial:	Last Name:	Other names:	
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -		
Date of Birth: / /	Social Security # - -	Do you have insurance? (circle one) Yes No Name of Insurance: _____		

Household Size: _____		
Name	**Date of Birth**	**Relationship to You**
	/ /	
	/ /	
	/ /	
	/ /	

Household Income

1	Did you file a federal income tax form last year?	Yes // No
2	If yes, what was your modified adjusted gross income (MAGI)? (see instructions on back page)	$
3	Do you expect your MAGI to be the same this year?	Yes // No

If you answered "No" to questions 1 or 3, please complete the section below:

Name	**Amount**	**Frequency (Circle one)**	**Source of Income**
You	$	Weekly Monthly Yearly	
Is this seasonal?	(Circle one)	Yes No	If yes, how many months?
Spouse	$	Weekly Monthly Yearly	
Is this Seasonal?	(Circle one?	Yes No	If yes, how many months?
Other	$	Weekly Monthly Yearly	
Is this Seasonal?	(Circle one?	Yes No	If yes, how many months?
		TOTAL ANNUAL: MUST BE FILLED IN	

NOTE: To comply with federal regulations, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Your yearly income tax return will be sufficient proof. Your annual income and your family size will be used to calculate your discount level.

PLEASE ATTACH A COPY OF YOUR FEDERAL TAX FORM 1040

OFFICE USE ONLY:

Slide Level: _____

Start Date: _____

Term Date: _____

Notes: _____

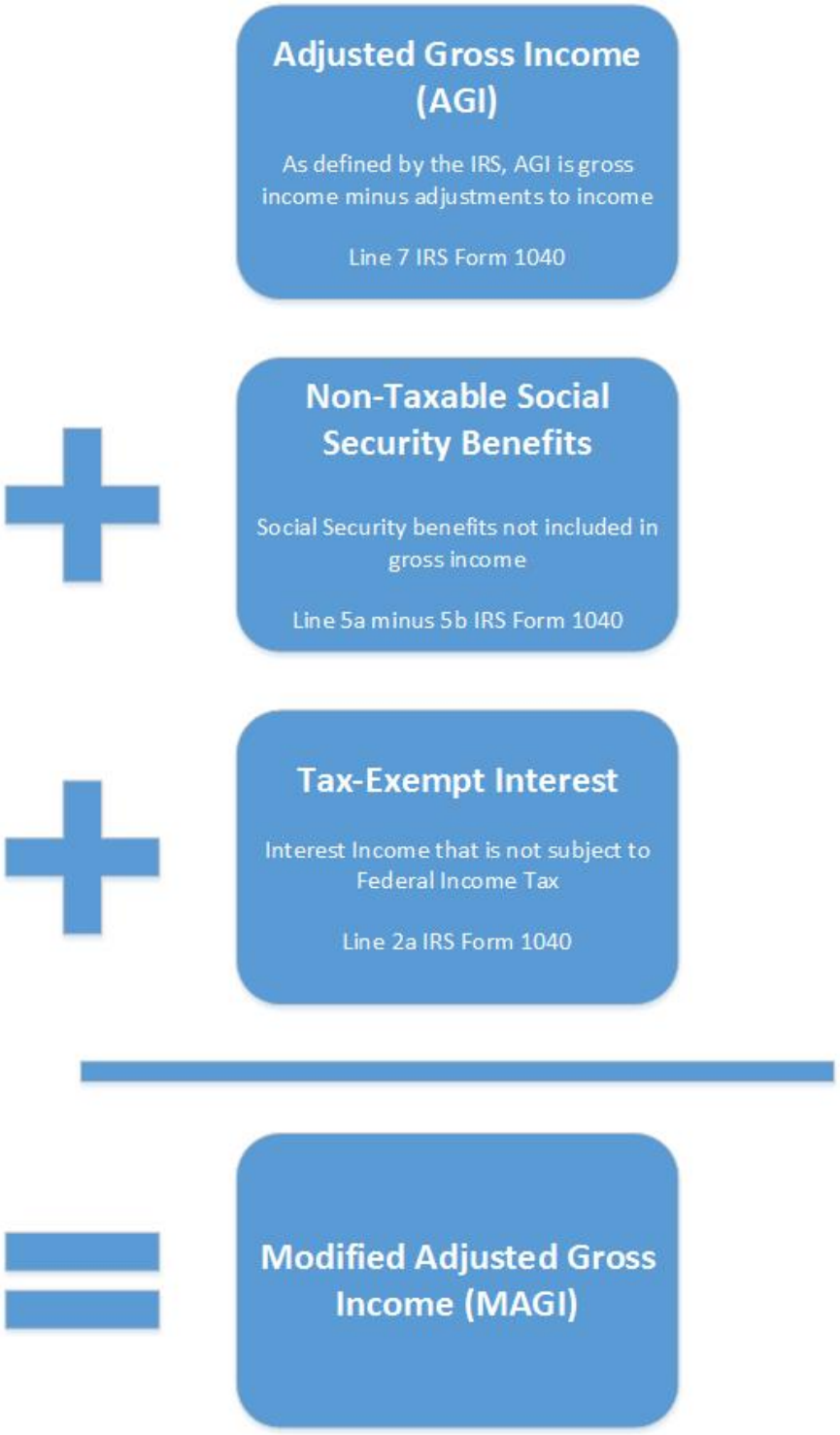
_____

_____

Staff Initials: _____

I do hereby affirm that the information provided on this application is true and correct to the best of my knowledge. If acceptance to the Sliding Fee Scale program is obtained under this application, I will comply with all rules and regulations of the program. Sawtooth Mountain Clinic will not be responsible for bills which I may incur that are outside the scope of the Sliding Fee Scale Program. Sawtooth Mountain Clinic, Cook County North Shore Health, and Oral Health Task Force may share my information to determine program eligibility. I hereby acknowledge that I read the foregoing disclosure and understand it.

Signature: _____ Date: _____


Adjusted Gross Income (AGI)
As defined by the IRS, AGI is gross income minus adjustments to income
Line 7 IRS Form 1040
+
Non-Taxable Social Security Benefits
Social Security benefits not included in gross income
Line 5a minus 5b IRS Form 1040
+
Tax-Exempt Interest
Interest Income that is not subject to Federal Income Tax
Line 2a IRS Form 1040
=
Modified Adjusted Gross Income (MAGI)