

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

Sliding Fee Scale Application

Patient Informatio	n								
First Name: Middle		le Initial:	il: Last Name:		Previous names:				
Mailing Address:				City:			State:		Zip:
Home Phone: () -				Cell Phone: () -			I		l
Date of Birth: / / Social Security #				Do you have health in Do you have health in Name of Insurance:				nce? Yes /	/ No
Family/Household	Size:								
Name of household member			Date of Birth		Relationship to You			NOTE: To comply with federal	
								-	ns, it is necessary for
									some personal s. Your answers will b
									ile and in strict
								confiden	ce. You must verify
			/	/				-	ome at least every
								year. Your yea	rly income tax return
Family/Household	Income							-	ifficient proof. Your
1 Did you file a fede	Yes // No				 annual income and family size will be used to calculate your discount level. PLEASE ATTACH A COPY OF YOUR MOST RECENT 				
2 If yes, what was your modified adjusted gross income (see instructions on back page)				MAGI)? \$					
3 Do you expect your MAGI to be the same this year?				Yes // No			_		
								FEDERA	L TAX FORM 1040
If you answered "No" to questions 1 or 3, please Household Member Amount Frequency (Complete this section: Circle one) Source of Income					
You	\$	We	Weekly Biweekly N					OF	FICE USE ONLY
		f yes, how many months?					Slide Le	vel:	
Spouse \$		We	Weekly Biweekly Monthly Yearly						te://
Is this seasonal? Yes // No If yes, how		es, how many r	how many months?					ate://	
Other	\$	We	ekly Biweekly	Monthly Yearly				Notes: _	
Is this seasonal?	Yes // No	lf ye	es, how many r	months?	nonths?				
	I						-		
TOTAL ANNUAL H (must be filled i			ME: \$					Staff Ini	tials:
o hereby affirm that the i	nformation prov	vided on	this applicatio	n is true and	l correct to	the best of my know	vledge.	If acceptance	e to the Sliding Fee Scale

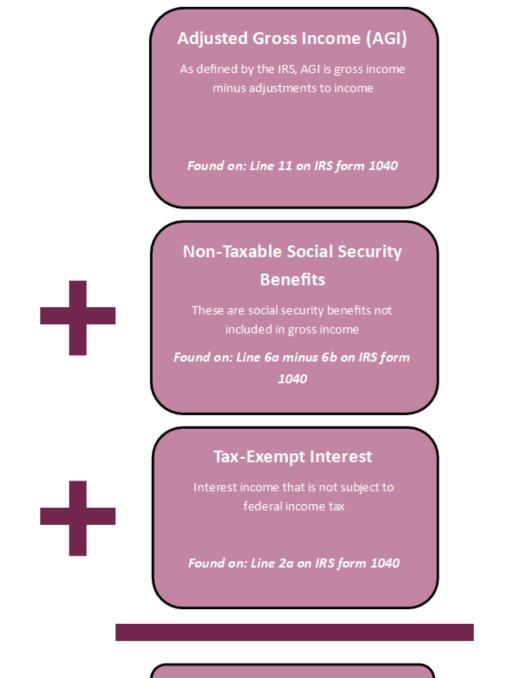
I do hereby affirm that the information provided on this application is true and correct to the best of my knowledge. If acceptance to the Sliding Fee Scale program is obtained under this application, I will comply with all rules and regulations of the program. Sawtooth Mountain Clinic will not be responsible 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: _____

Γoday's	Date:	
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How to calculate your Modified Adjusted Gross Income (MAGI) from your 2023 1040 Tax Return



Modified Adjusted Gross Income (MAGI)