Sawtooth Mountain Clinic

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

Sliding Fee Scale Application

Patient Information				
First Name:	Middle Initial:	Last Name:	Previous names:	
Mailing Address:		City:	State:	Zip:
Home Phone: ( ) -		Cell Phone: ( ) -		
Date of Birth: / /	Social Security # - -	Do you have health insurance? Yes // No Name of Insurance:		

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

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 family size will be used to calculate your discount level.
PLEASE ATTACH A COPY OF YOUR MOST RECENT FEDERAL TAX FORM 1040

Family/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 this section:

Household Member	Amount	Frequency (Circle one)	Source of Income
You	$	Weekly Biweekly Monthly Yearly	
Is this seasonal?	Yes // No	If yes, how many months?	
Spouse	$	Weekly Biweekly Monthly Yearly	
Is this seasonal?	Yes // No	If yes, how many months?	
Other	$	Weekly Biweekly Monthly Yearly	
Is this seasonal?	Yes // No	If yes, how many months?	

TOTAL ANNUAL HOUSEHOLD INCOME: $
(must be filled in)

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: _____ Today's Date: _____/____/_____

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How to calculate your Modified Adjusted Gross Income (MAGI) from your 2023 1040 Tax Return