FIRST CHOICE
PEDIATRICS

Sliding Fee Discount Application

Name of Head of Household:	Place of Employment:		
Street:	City:	State:	Zip:
Phone:	Patient Name:		

Please list spouse and dependents under the age of 18 years old.

Name	Date of Birth	Name	Date of Birth
Self:		Dependent:	
Spouse:		Dependent:	
Dependent:		Dependent:	
Dependent:		Dependent:	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.	$	$	$	$
Income from business, self-employment, and dependents	$	$	$	$
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income	$	$	$	$
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, pay stubs, or other information verifying income may be required before a discount is approved.**

I certify that the family size and income information shown above is correct.

Name (Print):	Signature:	Date:

Office Use Only

Approved Discount:	
Approved By:	
Date Approved:	

Verification Checklist:	Identification/Address: Driver's license, utility bill, employment ID, or other	
	Income: Prior year tax return, three most recent pay stubs, or other	
	Insurance: Insurance Cards	