Ponderosa Family Care

Sliding Fee Discount Application

127 E. Main St, Payson AZ 85541

It is the policy of Ponderosa Family Care to provide essential services regardless of the patient's ability to pay. Ponderosa Family Care offers discounts based on family size and annual income.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

NAME: _____

STREET: _____ **CITY:** _____**STATE:** _____

ZIP: _____ **PHONE:** _____

Please list all household members, including those under the age of 18.

	Name	Date of Birth
SELF		
OTHER		
OTHER		
OTHER		

Guarantor Employment Details:

Hourly Rate $		Hours per Week		x 52 wks = Total Gross Amount $	

Other Types of Incomes: (monthly amount)

Alimony	$	Disability	$		
Child Support	$	Pension	$		
SSI/SSA	$	Retirement	$		
ADC	$	Public Assist.	$		
Second Job	$	Other Income	$	x 12 mos = Total Gross Amount $	

Spouse Employment Details:

Hourly Rate $		Hours per Week		x 52 wks = Total Gross Amount $	

Other Types of Incomes: (monthly amount)

Alimony	$	Disability	$		
Child Support	$	Pension	$		
SSI/SSA	$	Retirement	$		
ADC	$	Public Assist.	$		
Second Job	$	Other Income	$	x 12 mos = Total Gross Amount $	

Other Household Member Employment Details:

Hourly Rate $		Hours per Week		x 52 wks = Total Gross Amount $	

Other Types of Incomes: (monthly amount)

Alimony	$	Disability	$		
Child Support	$	Pension	$		
SSI/SSA	$	Retirement	$		
ADC	$	Public Assist.	$		
Second Job	$	Other Income	$	x 12 mos = Total Gross Amount $	

TOTAL GROSS YEARLY INCOME (comined from above)	$	Family Size	

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

Name: (Print) _____

Signature: _____

Date: _____

Name: (Print) _____

Signature: _____

Date: _____

Name: (Print) _____

Signature: _____

Date: _____

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved by: _____ **Date:** _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent paystubs, or other		

Self-declaration of income may also be used