

DFD Russell Medical Center Sliding Fee Discount Application

This application is to be completed by all individuals requesting discounted services under the DFD Russell Medical Center sliding fee program. Please provide all information requested below.

Name:	Telephone No.:
Address:	

Total Number of Household Members:			Income (complete one column)		
	Name	Date of Birth	Weekly	Monthly	Annual
Self					
Spouse					
Children					

Note: Include all persons in household and their income from all sources, including wages, tips, social security, disability, death benefits, pensions, annuities, self-employment income, alimony, child support, income from trusts or estates, military, unemployment, public aid and all other sources.

Information Required To Be Submitted With This Application

This information is confidential and will be used only for the evaluation completed by our finance staff. It will not be disclosed nor will it become part of any medical record.

If approved, sliding fee discounts are valid for one year from the date of approval.

1. **A complete copy of your last individual income tax return (usually Form 1040). Include all schedules and attachments.**
2. **Two recent forms of employment income, such as pay stubs, or one social security, unemployment or other benefit check stub.**
3. **Maine Care benefits status Letter, if required.**

Certification of Accuracy

I certify that the information provided above is complete and accurate and that I have disclosed all sources of household income. I understand if it is later determined that I have materially misrepresented any of this information DFD Russell Medical Center has the right to bill me for discounts previously allowed and I agree to pay all such charges.

Signature: _____

Date: _____

DFD use only:

Centricity Number: _____

Date received: _____

Approved by: _____

Discount category: _____

Date Approved: _____

Date to Quest: _____

