Wheeler | Innovative Care. Positive Change.

SLIDING SCALE APPLICATION

_____ _____ _____

Print Client Name *Date of Birth* *Client Number*

Income Verification:

Are you employed? □ Yes □ No

Are you collecting any unemployment benefits? □ Yes □ No □ N/A

Verification of all income received from an employer or from the CT Department of Labor must be attached to this form in order to process your application.

Gross Family Income Determination:

Income Source	Hourly Pay Rate	# of Hours Worked Weekly	Weekly Pay Amount	Monthly Pay Amount (weekly pay x 4.3)	Total Income
Self Income	$ /hr.	hrs.	$	$	**$**
Spouse/Significant Other's Income	$ /hr.	hrs.	$	$	**$**
Other Weekly or Monthly Income Source: _____			$	$	**$**
				Gross Monthly Income Total	**$**
				Gross Annual Income Total (monthly x 12)	**$**
				Persons in Household	
				INTERNAL USE: Sliding Fee Scale Category Determination (refer to Sliding Fee Scale)	

Service Type	Fee	Service Type	Fee
Intake	$	Medical Office Visit – New	$
Outpatient Services	$	Medical Office Visit – Established	$
Intensive Outpatient (IOP)	$	Preventative Office Visit	$
Behavioral Health Group	$	Dental – Diagnostic & Preventive	$
Psychiatric Evaluation	$	Dental – Specialty	$
Med Management	$	Dental – Complex Services	$

Attestation:

By signing below, I attest to the fact that the information which I have provided above is truthful and accurate to the best of my knowledge. I acknowledge I am obligated to contact Wheeler Clinic if my income or household status changes.

Patient/Client Signature: _____ Date of Signature: _____

Internal Use Only: **Effective Date of Fee:**_____

Reviewing Staff Name (print):_____ **Date:**_____

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