SAINT YOUSTINA
DISCOUNTED/SLIDING FEE AND
FAMILY ASSISTANCE PLAN APPLICATION
All Facilities

It is SAINT YOUSTINA's policy to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon family income and size. 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 the center but not those services which are purchased from outside, such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and similar services. In the hope that your economic health improves, discounts apply only to current, not future services. This form must be completed annually and/or if there are any changes. Please inquire at the front desk if you have questions.

*Number of related persons living in your household: _____

NAME OF HEAD OF HOUSEHOLD:			
	LAST	*FIRST*	*MIDDLE*
HEALTH INSURANCE PLAN:		**SS#:**	
ADDRESS:		**CITY:**	**ZIP:**
HOME PHONE:	**CELL PHONE:**	**WORK PHONE:**	
EMPLOYER:		**OCCUPATION:**	

PLEASE LIST SELF, SPOUSE, AND DEPENDENTS UNDER THE AGE OF 18.

NAME		Date of Birth	NAME		Date of Birth
SELF			**DEPENDENT #3**		
SPOUSE			**DEPENDENT #4**		
DEPENDENT #1			**DEPENDENT #5**		
DEPENDENT #2			**DEPENDENT #6**		

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Social Security, Pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business, self-employment, and dependents				
Rent, interest, dividend, and other income				
TOTAL INCOME				

Note: Include income from all related persons in household and income from all sources including gross wages, tips, social security, disability, pensions, annuities, Veteran's payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.

VERIFICATION C2HECKLIST (Attach copies)	YES	NO
Identification/Address: Driver's License, Birth Certificate, Employment ID, Social Security Card, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance card(s)		

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print): _____ Signature/Date: _____

OFFICE USE ONLY

Patient Name: _____ Discount: _____

Date of Service: _____ Approved by:

_____