

### **Sliding Fee Discount Program Application**

It is the policy of Wellness Homes of Chicago to provide essential primary care and behavioral health services regardless of the patient's ability to pay. Wellness Homes of Chicago offers discounts through a sliding fee discount program based on family size and annual income.

Our sliding fee discount program helps make primary care and behavioral health services more affordable for eligible individuals and families. To apply, please complete and submit this form along with the required financial documentation, either online or at the front desk. Upon approval for the sliding fee discount program, you must complete this form every 12 months, or sooner if your financial situation changes so we can review your eligibility.

The discount applies only to comprehensive primary care and behavioral health services as outlined in our policy. Non-comprehensive primary care and behavioral health services including, but not limited to weight loss programs, cryotherapy, certain injections and medications, and certain laboratory tests, are excluded from the discount. Patients will be informed when services are not covered under the Sliding Fee Discount Program.

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#### **Income Verification**

Income is defined as the total annual income for the household before taxes. Income must be reported for each member of the household that makes up the family size.

Please list the total amount of annual income received from each source for all members of your household.

Source	Self (Enter \$ amounts)	Other family members  (Enter \$ amounts)	Total
Gross wages, salaries, tips, etc.			
Income from business and self-employment.			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income.			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.			
TOTAL INCOME:	\$	\$	\$

**Proof of income**: For every individual in your household who receives income, please provide the two (2) most recent pay stubs or equivalent proof of income.

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#### Affidavit of Income

I hereby certify that the information and belief.	n I have provided is true, accurate, and	complete to the best of my knowledge
Printed Name	Signature	Date
	– OFFICE USE ONLY –	
Patient Name:	MRN: _	

Approved Discount: \_\_\_\_\_ Reviewed By: \_\_\_\_\_ Date Reviewed: \_\_\_\_

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment identification, or other		
Proof of income		

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