OFFICE USE ONLY SLIDE CLASS: A B C D

P.O. Box 665
Savannah, TN 38372
731-925-2300

Sliding Fee Application FM-M-102

You may qualify to pay a reduced price for some services and treatments at our health centers. The exact amount you pay depends on your income and family size. This is the "Sliding Scale." All patients, with or without insurance, are encouraged to complete an application to participate in our Federal grant.

Once you qualify for the Sliding Scale, you can use it for 12 months. If your income or household size changes during those 12 months, you must let us know.

Name of Applicant: _____ Birthdate: _____
Address: _____ City, State, and Zip: _____
Phone: _____ Alternative Phone: _____

Do you currently qualify for food stamps? Yes No

Household Members	Birthdate	Income Source	Gross Income	How often received

Total Annual Income: _____

I, the applicant, agree to inform Lifespan if there is any change in my household income at any time. I understand that it is my responsibility to supply all requested information, which may include W-2 forms as well as my tax return. I also understand that, if do not have the required information at my next visit, I will be taken off the Sliding Scale until such information is submitted.

Applicant Signature: _____ Date: _____

Signature of Lifespan Staff: _____ Date: _____