Cook Area Health Services, Inc. dba Scenic Rivers Health Services

Sliding Fee Scale Application

Please complete this application and return it to your Scenic Rivers clinic. If you have any questions about the Sliding Fee Scale or this application, please contact us at 218-666-5941 Option 2.

	Full Name	Birthdate	Social Security Number
Head of Household		/ /	- -
Spouse		/ /	- -
Children		/ /	- -
		/ /	- -
		/ /	- -
		/ /	- -
		/ /	- -
		/ /	- -
		/ /	- -
		/ /	- -

Street Address/PO Box #: ______________________________

City/State/Zip Code: ______________________________

Do you have Medical/Dental Insurance: ☐ No ☐ Yes **Insurance Carrier:** ______________________

<u>Please Combine Annual Income of All Household Members in the Spaces Below:</u>

Income Source	Amount
Wages and Salaries (before deductions)	
Public Assistance (monetary benefits only)	
Social Security Income	
Unemployment	
Worker's Compensation	
Strike Benefits	
Veteran's Benefits	
Military Family Allotments	
Alimony	
Child Support	
Pensions	
Regular Insurance or Annuity Payments	
Dividends, Interests, Rents, Royalties, Estates, Trusts	
Self-Employment (after business deductions)	
Other Income: ______________________	
Total Annual Income	

<u>Please remember to attach proof of income to this application</u>

I understand a false answer to any question in this application is cause for disenrollment and may be punishable by fine and imprisonment. (U.S. Code Title XVIII, Section 1001)

______________________________ ______________________

Signature **Date**