ComWell - Sliding Fee Discount Application

Name of Applicant:_____ Client ID_____ Phone Number:_____

Address: _____

Place of Employment: _____

Relationship to Client: _____

Please list spouse and dependents under age 18:

Self:_____ Date of Birth _____

Spouse:_____ Date of Birth _____

Dependent Name:_____ Date of Birth _____

Dependent Name:_____ Date of Birth _____

Dependent Name:_____ Date of Birth _____

Dependent Name:_____ Date of Birth _____

Annual Household Income: Please provide copies of tax returns, pay stubs or other information verifying income to help us determine eligibility. Determination is not made until documentation is attached.

Source	Self	Spouse	Other	Total
Gross Wages, salaries, tips, etc.				

I certify that the family size and income information shown above is correct:

_____ _____

Signature **Date** **Print Name**

Note: _____

_____

Approved by: _____ Print Name: _____
Signature

Date of Approval:_____ Entered to EHR? ☐Yes ☐No

ComWell
WHERE COMMUNITY MEETS WELLNESS

FAX: 1.888.388.1971