

**Sliding Scale Fee Discount Program Application**

It is the policy of Sunrise Treatment Center to provide essential services regardless of the patient’s ability to pay. Sunrise Treatment Center discounts are based on family size and annual income.

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 Sunrise but does not include medication. You must complete this form every 12 months or if your financial situation changes.

Name:

Address:       City:       State:       Zip:

**Please list all household members, including those under age 18.**

|  |  |  |
| --- | --- | --- |
|  | **Name** | **Date of Birth** |
| **SELF** |  |  |
| **OTHER** |  |  |
| **OTHER** |  |  |
| **OTHER** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Source** | **Self** | **Other** | **Total** |
| **Gross wages, salaries, tips, etc.** |  |  |  |
| **Income from business and self-employment** |  |  |  |
| **Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, 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** |  |  |  |

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

|  |
| --- |
|  |

**Print Name**

|  |
| --- |
|  |

|  |
| --- |
|  |

**Signature Date**