Sliding Fee Scale Discount Program Application Form

Patient Information		Today's Date: / /		
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /				

Household Size: (Please list all household members, including those under age 18)	
Name	Date of Birth
	/ /
	/ /
	/ /
	/ /
	/ /

Household Income					
Name	Amount	Frequency (Circle one)		Employer:	
You	$	Weekly Monthly Yearly			
Children	$	Weekly Monthly Yearly			
Other	$	Weekly Monthly Yearly			
TOTAL					
Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	$

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.
Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

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I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Multicultural Wellness Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Multicultural Wellness Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:__________________________ Name (Print):___________________________________

Signature:____

Please drop off or mail signed application to:

Multicultural Wellness Center
10 Winthrop Street, 3rd Floor
Worcester, MA 01604
Attn: Business Office Director

Office Use Only

Patient Name: ____

Approved Discount: ____

Approve by: ____

Date Approved: ____

Verification Checklist	Yes	No
Identification /Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		

Self-declaration of income may also be used

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It is the mission and policy of the Multicultural Wellness Center (MWC) to provide behavioral services to consumer's regardless of the consumer's ability to pay. MWC offers discounts 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.

This discount will apply to all serviced at this clinic. You must complete this application form every 12 months or if your financial situation changes.