Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(please print)

 Last First MI

Relationship to Client (check one): [ ]  Self [ ]  Parent [ ]  Guardian [ ] Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(please print)

 Last First MI

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip:

Home Phone: Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Cell [ ]  Work [ ]  Other

The Loyola Clinical Centers’ fees vary depending on the service(s) provided. If you are unable to pay the full fee, you may apply for an adjustment. In order to maintain the Clinic, we expect you to pay as much of the full fee as you can. This form and the adjusted fees may be revised and/or reviewed at any time as necessary. For clients between the ages of 0-18, the discount will be based on the parent/guardian’s income. For clients between the ages of 18-24, the discount will also be based on the parent/guardian’s income, unless the client provides documentation that he/she is not claimed as a dependent/exemption on another person’s Federal income taxes.

|  |  |
| --- | --- |
| **Financial Resources for the Year:**The financial information you give below should reflect all of your current annual income sources. ***Please provide proof of income (last 30 days*** ***of stubs/bank statements/Tax returns/etc.)*** | **Unusual Living Expenses:**Typical living expense (e.g., rent/car payments\_ have been taken into account in our fee schedule. Please list any unusual expense on a **per year** basis. ***Please provide bills/statements for unusual expenses.*** |

|  |  |  |  |
| --- | --- | --- | --- |
| Your Current Annual Income | $ | Annual Contribution toward Tuition | $ |
| Spouse’s Current Annual Income | $ | Annual Daycare | $ |
| Annual Alimony Received | $ | Annual Alimony Paid | $ |
| Annual Child Support Received | $ | Annual Child Support Paid | $ |
| Annual Social Security Benefits | $ | Unusual Medical Expenses | $ |
| Other Income | $ | Other (please specify) | $ |
|  |  |  |  |
| **Total Annual Income** | **$** | **Total Unusual Living Expenses** | **$** |

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_ Employment: [ ]  Full [ ]  Part [ ]  Unemployed [ ]  Student

# of Dependent Children: \_\_\_\_\_\_\_ # of Children in Daycare: \_\_\_\_\_\_ # of Children in College: \_\_\_\_\_\_\_\_

Do you receive Medicare and/or Medicaid benefits? Yes No

**The information I have given is to the best of my knowledge complete and accurate.**

**Signature: Date:**

**\*Office Use Only\***

Percent Discount: Division: Date Approved:

**What is a Sliding Scale Fee?**

Loyola Clinical Centers offers a sliding fee program to assist clients who may not be able to afford the full cost of an office visit. The sliding scale discount is determine utilizing household income, dependents and unusual expenses. The discount is based off of the national federal poverty guidelines.

To apply you must provide the following:

**Current Tax Return or W’2 from yourself and or your spouse or significant other if they are employed.**

**(2) Current pay stubs or** (2) of yours **and** (2) of your spouse or significant other, if applicable.

 **Or**

 **Un-employment paperwork** - (1) of yours and (1) of your spouse or significant other if applicable.

**Social Security** or **letter of benefits from the government.**

**\*\* Typical** **living expenses (rent/mortgage, car payments insurance, utilities, etc.) have already been taken into account with our fee schedule.**

 However, unusual living expenses can be deducted from your total annual income to help increase your amount of discount for our services.

**Examples of Unusual Expenses:**

Annual Contribution toward Tuition

Annual Daycare

Annual Alimony/ Child Support Paid

Unusual medical expenses (diabetic supplies, monthly prescriptions, etc.)

**\*\* Receipts of unusual living expenses must be provided in order to deduct them from yearly income.**

The FIF (**Financial Information Form**) must be submitted on an annual basis to maintain your adjusted fee.

If there is a change in your economic situation that creates hardship, you may apply for a review of your fee by resubmitting an FIF.