



Sliding Fee Discount Program Application

MRN: _____

We encourage patients to apply, even if you have insurance.

Office Use Only

Full Name: _____ Date: _____ Number of People in Household: _____

HOUSEHOLD INCOME REQUIRED

- Household Income \$ _____ Bi-weekly Monthly Yearly **OR CHECK BELOW:**
- Under \$15,960 \$25,000 - \$29,999 \$40,000 - \$44,999 \$55,000 - \$59,999 \$70,000 - \$74,999
- \$15,961 - \$20,999 \$30,000 - \$34,999 \$45,000 - \$49,999 \$60,000 - \$64,999 Over \$75,000
- \$21,000 - \$24,999 \$35,000 - \$39,999 \$50,000 - \$54,999 \$65,000 - \$69,999 Choose not to disclose

TO DECLINE THE SLIDING FEE DISCOUNT SIGN BELOW**I do not want to apply for sliding fee discount program at this time.**

Signature: _____ Date: _____

TO APPLY FOR THE SLIDING FEE DISCOUNT PROGRAM

Please attach copies of your most recent IRS 1040 form, social security income awards letter, last 30 days of paystubs and/or proof of any earnings. EARNINGS MAY INCLUDE: Taxable income earned, taxable net self-employment income, social security income, alimony/spousal maintenance, unemployment compensation, taxable income (pension, retirement, annuities, interest, estate/trusts, etc.). **List ALL dependents (including you) that you would claim on your tax return, their ages and earnings.**

NAME	DATE OF BIRTH	SOURCE OF INCOME	GROSS EARNINGS	BI-WEEKLY, MONTHLY OR YEARLY

List additional family members on the back of this application.

- **I must provide proof of income within 30 days of signing this form to determine eligibility.**
- I confirm that the information I give is true and correct. Noble may check this information.
- I will notify Noble within 10 days if my income, household size, or other information changes. If I do not report changes, I will have to pay the full cost of my care.
- If my income and household size do not change, my discount may last up to one year. I must reapply each year to see if I still qualify. Discounts are based on Federal Poverty Guidelines, which change each year.
- **Payment is due at the time of my visit.**
- **Dental special service fees must be paid in full before dental work can begin.**
- If I am referred to another provider or dentist, I am responsible for the cost of that visit.
- Some lab tests are billed by another company (Labcorp), and I am responsible for paying those bills.
- If I cannot pay, I will talk with a Noble Financial Counselor as soon as possible.

Patient Signature: _____
(or Parent/Guardian/Legal Representative)

Date: _____

Office Use Only: Application Level A B C D E County _____Household Income \$ _____ Supporting Documentation (or Self-Attestation form required).

Approved by Noble Staff Name _____ Date _____