



"A NON-PROFIT ORGANIZATION SINCE 1979"

9862 Chapman Ave. Garden Grove, CA 92841

Tel: (714) 620-7001 – Fax: (714) 620-7091

www.southlandintegrated.org | info@southlandintegrated.org

Sliding Fee Discount Application

It is the policy of Southland Integrated Services, Inc. to provide essential services regardless of the patient's ability to pay. Discounts are being offered 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 is eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside; including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation or dependents changes.

Name: _____ DOB: _____

Family size (total number, including yourself): _____

Names (excluding yourself):	Age:	Relationship (blood/ adoption or # on tax return):

Please indicate your source of household income

☐ Your gross wages	\$
☐ Gross wages of spouse/partner, or others with whom you live with	\$
☐ Net profits from self-employment	\$
☐ Net income from real estate or personal property (rental income)	\$
☐ Alimony/Child support	\$
☐ Retirement income (SS, etc.)	\$
☐ Worker's Compensation	\$
☐ Veteran's Payment	\$
☐ Training Stipends	\$
☐ Unemployment Benefit	\$
☐ Others:	\$
TOTAL INCOME	\$

Proof and Verification: Income Verification documentation:

- ☐ Pay vouchers or pay stubs for prior 2 months
- ☐ Income tax return for prior calendar year
- ☐ Award letter from County Welfare Department or other Government Agency documenting eligibility for assistance



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- ☐ College financial award letter, unemployment letter, letter from parent or caretaker, or other income from partner or spouse, a current letter from employer (within 12 months).
 - ☐ Other (specific e.g., self-declaration/temporary eligibility)
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By signing this form, I agree to the following:

- ✓ I attest to the above income information
- ✓ I will pay for clinic visits, lab fees, record readings, procedures, and any additional fees asked at the time of service. If payment is not made, a bill will be sent to my address and payment will be mailed in.
- ✓ I understand that not all services/supplies/labs may be included in the nominal or flat discount amount and that any extra charges will be identified to me prior to services being provided and I will be responsible for those additional amounts, if I so elect the services.

**** I hereby declare to the best of my knowledge that the above information is true and correct in every aspect. Falsifying this information may result in Southland Integrated Services, Inc charging me for reimbursement of all costs incurred.**

Signature: _____ Date: _____

OFFICIAL USE ONLY	Verified by:	Date:
SFDP-determination: ☐ A ☐ B ☐ C ☐ D ☐ E		
All required documentation has been provided and verified: ☐ YES ☐ NO-Pending Docs: _____ _____ ☐ TEMPORARY eligibility granted. ☐ Patient notified they must bring in the documents at the next visit or no later than 15 days from the date of this visits. (Date due: _____)		
Correct SFDP has been entered into the Practice Managed System:		