Juniper Health, Inc.
2024 Sliding Fee Scale Eligibility Form

First Name Middle Initial Last Name

Address City State Zip

_____ _____ Male Female

Date of Birth Phone

Do you have insurance: Yes No

Please list spouse and dependents living in your household.

Name _____ DOB_____ Relationship _____ Income_____

Name _____ DOB_____ Relationship _____ Income_____

Name _____ DOB_____ Relationship _____ Income_____

Name _____ DOB_____ Relationship _____ Income_____

Name _____ DOB_____ Relationship _____ Income_____

By my signature below I attest that the information provided herein is complete and accurate. **I understand that I am required to provide <u>ENTIRE HOUSEHOLD</u> income information and documentation within 10 days for the purpose of determining my eligibility to participate in the Sliding Fee Scale Program.** I agree to inform Juniper Health, Inc. of any changes of condition or circumstance that might impact my eligibility to participate in the Sliding Fee Scale Program. Any untruthful or fraudulent information provided may be grounds for denial of assistance.

_____ _____

Patient Signature Date Authorized Employee Signature Date

OFFICE USE ONLY

Annual **Household** Income: $_____ Family Size: _____ Patient Number _____

Percentage of SFS: _____% Expiration Date: _____ Medicaid Website Checked: _____

CFO Approval Signature _____ PM System Updated: _____