

# Juniper Health, Inc.

## 2025 Sliding Fee Scale Eligibility Form

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First Name	Middle Initial	Last Name	
Address	City	State	Zip
Date of Birth	Phone	Male	Female

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 ENTIRE HOUSEHOLD 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
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OFFICE USE ONLY

Annual **Household** Income: \$ \_\_\_\_\_ Family Size: \_\_\_\_\_ Patient Number \_\_\_\_\_

Percentage of SFS: \_\_\_\_\_ % Expiration Date: \_\_\_\_\_ Medicaid Website Checked: \_\_\_\_\_

CFO Approval Signature \_\_\_\_\_ PM System Updated: \_\_\_\_\_