Redwoods Rural HEALTH CENTER

Family Health Care

Temporary Sliding Scale Application

Patient/Guardian Name (please print) _____

How many members live in the household? _____

Total Household Income: $_____ per week $_____ per month $_____ per year

Income Source: _____

Birth Date of Patient: _____/_____/_____

By signing this temporary Sliding Scale application, I acknowledge that I agree to provide verification of income on my next visit before additional services can be given under the sliding scale program.

_____ _____/_____/_____

Signature of Person Applying for Sliding Scale Date

_____ _____/_____/_____

Signature of Redwoods Rural Health Center Staff Date

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