Heartview Foundation

Sliding Fee Discount Application

It is the policy of Heartview Foundation, to provide essential services regardless of your ability to pay. Heartview is committed to assisting you to meet the financial responsibility associated with SUD treatment. Heartview will help you explore all available financial support/resources to cover your financial responsibility for treatment.

Discounts are 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 are 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 changes.

Patient Information:

Name_____Date of Birth: _____

Are you Employed? Yes ☐ No ☐ If yes, list employer If no, List last day worked

Mailing Address:_____

City: _____ State: _____ Zip: _____

Annual Household Income:

Source: *Gross wages, salaries, tips, etc. Income from business, selfemployment, and dependents*
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources

Self:	Spouse:	Other:	Total:

Total:

List spouse and dependents under age 18:

Name:	Date of Birth:	Name:	Date of Birth:
Spouse:		Dependent:	
Dependent:		Dependent:	
Dependent:		Dependent:	
Dependent:		Dependent:	

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.
I certify that the family size and income information shown above is correct.

Print Name:_____

Patient Signature_____ Date:_____

OFFICE USE ONLY

Patient Name:_____

Approved Discount: _____

Approved by: _____

Date Approved: _____

Verification Checklist:

	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		