Exhibit D

SLIDING FEE DISCOUNT PROGRAM

It is the policy of Saban Community Clinic to provide healthcare services regardless of a patient's ability to pay. Discounts are offered based on your household size and income. Please complete the following information and return to the front desk to determine if you and the members of your family/household are eligible for Saban's Sliding Fee Discount Program.

APPLICATION / ATTESTATION

PATIENT INFORMATION:	TODAY'S DATE:
First Name:	Last Name:
Address:	
Date of Birth:	Home(Cell):
For Official Use only: Account #	

Household/Family size is defined A member of a household can be a relative or a non-relative, but in order for the person to be claimed as a member of the household, he or she must meet the relationship requirements described below.

- Lineal descendant (child, grandchild, great-grandchild; step-lineal descendants such as stepchildren are included).
- Spouse.
- Foster child(ren).
- Brother or sister (includes stepbrothers/stepsisters and half-brothers/half-sisters).
- Lineal ancestor (parent, grandparent, great-grandparent; step-lineal ancestors are included).
- Niece, nephew, aunt or uncle (not including relations by marriage).
- In-law (father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law).
- Anyone else who is neither related nor married to patient, but who currently lives in his or her home, has done so in the past consecutive six months, and financially supports or is supported by the patient.

Family/Household Size:

Name:	Date of birth:	Relationship
1. Self:		
2. Spouse:		
3. Dependent:		
4. Dependent:		
5. Dependent:		
6. Dependent:		
7. Dependent:		
8. Other:		
9. Other:		
TOTAL FAMILY/HOUSEHOLD SIZE: ____		

Income is defined as money received on a regular basis before payments for personal income taxes, social security taxes, union dues, Medicare deductions, retirement contributions or other deductions, and does not include non-cash benefits (such as food stamps, health benefits or subsidized housing)

Income includes, but is not limited to money received from the following sources

- Employment earnings.
- Disability payments.
- Social security payments.
- Net rental income.
- Net self-employment income (profit) after business expenses are deducted.
- Child support and alimony payments.
- Unemployment compensation.
- Child support and alimony payments.
- Insurance annuities payments.
- Pension and retirement payments.

Income does not include money received from the following sources:

- Proceeds, gains from property sale, such as stocks, bonds, house, car (unless the person is engaged in the business of selling such property, in which case the net proceeds would be counted as income from self-employment).
- Tax refunds.
- Withdrawals of savings.
- Borrowed money.
- Inheritances.
- Grants (such as scholarships).
- Value of food stamp coupons or other supplemental assistance program disbursements.

Household Income

	Gross Income:	Frequency:	Source of Income:
1. Self:	**$**	Weekly BiWeekly Monthly Yearly	
2. Spouse:	**$**	Weekly BiWeekly Monthly Yearly	
3. Dependent:	**$**	Weekly BiWeekly Monthly Yearly	
4. Dependent:	**$**	Weekly BiWeekly Monthly Yearly	
5. Dependent:	**$**	Weekly BiWeekly Monthly Yearly	
6. Dependent:	**$**	Weekly BiWeekly Monthly Yearly	
7. Dependent:	**$**	Weekly BiWeekly Monthly Yearly	
8. Other:	**$**	Weekly BiWeekly Monthly Yearly	
9. Other:	**$**	Weekly BiWeekly Monthly Yearly	
TOTAL INCOME	**$**	Weekly BiWeekly Monthly Yearly	

You must verify the Household income at least once **per two** years, or you are required to report more frequently upon a significant change in the income level or family size.

Acceptable **forms of proof** of income are as follows:

- Most recently filed Federal tax return transcript. (Certified tax return records available online at http://www.irs.gov/Individuals/Get-Transcript).
- Most recent IRS Wage and Tax W-2 form.
- One pay stub from the prior six months.
- Social Security, disability or pension benefit statement.
- Documents of other government assistance such as CalFresh, CalWORKS.
- Unemployment Benefit statement.
- IRS verification of non-filing letter with proof of income from individual(s) providing financial support to the patient. (Verification of non-filing letters obtainable online at http://www.irs.gov/Individuals/Get-Transcript.)
- Letter issued by employer stating gross salary.
- Letter from third-party organization/advocacy group stating gross earnings and employment status. (The letter must include specific contact information.)
- Signed affidavit from individual supporting the patient, stating the amount of financial support and specific contact information.
- Signed affidavit from patient describing his/her employment status and income source.

If you do not have proof of income at your initial visit, this form will serve as a self-attestation until you can provide proof of income (initial visit may be on an honor system), and you are required to provide the requested documentation by the second visit to be considered eligible for the **two-year** period.

_______________________________________ _________________________________ _________________

Name(Print) Signature Date

Verification Checklist- Official use only **Staff Initial:____**	**Yes/No**
Identification: Driver's license, birth certificates, social security care or other (NOT required for Sliding fee Discount eligibly	
Proof of Income (Patient notified they have to provide proof of income by their next visit to be considered eligible for SFD **for 2 yr** period):	
If unable to provide proof, why:	
Total **Annual Income** Verified:$______________ Total Household size:_______	
Approved by:____	
Effective Date (enter into "EMR,Check self-pay, assign):______________________	
Expiration Date: (enter into "EMR"):________________________	
Siding Fee Scale System calculated: A__ B__ C__ D__ E__ F__(>200%-no discount)	