IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Thielen Student Health Center
Ames, Iowa 50011-2260
515 294-5802
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# Sliding Fee Discount (SFD) Application

The Thielen Student Health Center (TSHC) will provide essential medical services regardless of the patient's ability to pay. Financial discounts may be offered based on financial need (e.g., taking into account family size and annual income). The discount will apply to all services received at TSHC, but not those services or equipment that are purchased from external providers and vendors, including reference laboratory testing, medications from the TSHC pharmacy, travel clinic, and other such services. This form must be completed every 12 months or sooner, if your financial situation substantially changes.

**Patient Information:**

| | |
|---|---|
| Patient Name (Last, First, Middle, Maiden): | Place of Employment: |
| Current Address (City, State, Zip): | |
| University ID#: | Date of Birth (MM/DD/YYYY): |
| Phone #: | Email Address: |

**Please list spouse and dependents under age 18, if appropriate**

| Name (Last, First) | Date of Birth (MM/DD/YYYY) |
|---|---|
| | |
| | |

**Annual Household Income**

| **Source*** | **Self** | **Spouse** | **Parents/Other** | **Total** |
|---|---|---|---|---|
| Gross wages, salaries, tips, etc. | | | | |
| Income from businesses, self-employment, and dependents | | | | |
| Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits | | | | |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance (financial aid), alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count. | | | | |
| **Total Income** | | | | |

If you reported no income, please explain how you are supporting yourself without income:

* Applicants must provide their completed FAFSA report and one of the following: prior year W-2, two most recent pay stubs, or Form 4506-T (if W-2 not filed) with this application. Self-employed individuals are required to submit their latest completed tax return with taxable income listed from the 1099 employment form. If applicant has no income, the Limited Income Statement must be completed. Applications submitted without the above requested information will not be considered.

**Limited Income Statement**

For the purpose of applying for the Sliding Fee Discount at Thielen Student Health Center, I have not received any income for the last 13 weeks including but not limitewd to employment, Social Security benefits, VA benefits, pension, unemployment, TANF, General Assistance, stipends, child support, alimony, workers compensation benefits, rental income, self-employed income, financial aid, and any under the table payments. I acknowledge and agree the statement noted within this Limited Income Statement and understand my application will be revoked if found not to be true. By signing this I am agreeing that the information above is accurate and correct.

Signature of Patient (or Legal Representative, if applicable)

Today's Date (DD/MM/YYYY)

**I agree and understand that:**

1. To be considered for the Sliding Fee Discount (SFD), verification of my income is mandatory.
2. By signing below, I agree that TSHC may contact each employer of all persons working in the above mentioned household and/or may contact various agencies to verify any source of income.
3. Within 5 business days, I will provide TSHC with a copy of all requested information, as listed, for all persons in the above mentioned household.
4. I will be asked to reapply for the SFD every year so TSHC can maintain an updated SFD application on file.
5. I am obligated to inform TSHC of any change in household size, income, and/or insurance.
6. I am also obligated to provide TSHC with any income information that is requested. Applications lacking required information will be denied without notice after 5 business days.
7. **Fraudulent self-reporting on any portion of this application disqualifies patients from participation in the SFD and may be punishable by law.**

**By signing below, I verify that all information provided in my SFD Application is true, current, and correct.**

| | |
|---|---|
| Patient's Printed Name | Today's Date (DD/MM/YYYY) |
| Signature of Patient (or Legal Representative, if applicable) | If applicable, Legal Representative's Printed Name and Relation to Patient (e.g., Mother, Father, Guardian, etc. |

Office Use Only:
Approved discount:_____ Approved by:_____ Date Approved: _____