Application/Self-Attestation Form – Sliding Fee Discount Program

Transformation Healthcare Inc. (THI) offers a Sliding Fee Discount Program to support access to services based on household size and income. Applicants must provide proof of income within five (5) business days, and eligibility may be re-evaluated periodically or upon any change in financial status. All information is subject to verification, and approved discounts apply only to eligible services moving forward from the date of determination. Any false or incomplete information may result in removal from the program and adjustment of account balances.

Patient Information

Patient Name	
DOB	
SS#	
Phone Number	

Family Size Definition:
For purposes of this program, family size refers to individuals living in the same household who are related by birth, marriage, or legal relationship. This includes immediate family members such as a spouse or partner, children, and dependents. Dependents are generally considered individuals age 19 or younger who rely on the household for financial support.

Circle One: 1 2 3 4 5 6 7 8 9 10 Other: ___________________

Household Members

Family Member Name	Date of Birth	Relationship

Total Family Income

Source	Self (Monthly)	Spouse	Other	Monthly Total
Gross wages, salaries, tips				
Social security, pension, veteran's benefits				
Alimony, child support				
Income from business/self-employment				
Unemployment/worker compensation				
Other income				
Total Annual Family Income				

Select one or more (Which Services Are You Seeking?)

☐ OP ☐ IOP ☐ PHP ☐ PRP ☐ ACT ☐ HH ☐ THERAPY ☐ MED MGT

Attestation
I certify that the information provided above is true, accurate, and complete to the best of my knowledge. I understand that verification is required for approval of the Sliding Fee Discount Program. I agree to notify Transformation Healthcare Inc. of any changes in my household size or income. Failure to report such changes may result in removal from the program and adjustment of my account balance. I acknowledge responsibility for any outstanding balances and understand that payment arrangements may be available.

Name (Print)	Signature/Date
Completed By	Expiration Date