EDUCATIONAL HEALTH CENTER OF WYOMING

1522 East A Street
Casper, WY 82601
(307) 234-6161

SLIDE QUALIFICATION WORKSHEET

Patient Name:____ DOB:____/____/______
(Full Name)

Guarantor Name:____ DOB:____/____/______

Account Number:____________________ Guarantor Account Number:________________

Patient	Full Name	DOB	Account #
Yes / No			
Yes / No			
Yes / No			
Yes / No			
Yes / No			
Yes / No			

Family Size for Slide Calculation [ ]

Frequency of Income	Type of Income	Amount of Income

Sliding Fee Scale Total Income [ ]

Sliding Fee Qualification (Circle One): **Level 1** **Level 2** **Level 3** **Level 4** **Level 5** **Level 6**

Length of Sliding Fee Scale Honored____________________________________
Slide Expiration Date:____________________________________
Comments:____________________________________
____

Patient Signature: ______________________________ **Date:** _____/_____/_____

Updated By:______________________________ **Date:**_____/_____/_____

UNIVERSITY OF WYOMING