THE UNIVERSITY of TENNESSEE
HEALTH SCIENCE CENTER
Department of Audiology and Speech Pathology

UT Hearing & Speech Center
Sliding Scale Fee Form

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Parents or Legal Guardian(s) (if applicable) _____

Sliding Scale Fee Information: (All fields are required)

Gross household income	Monthly	Yearly
Employment Income	$_____	$_____
Social Security/Retirement	$_____	$_____
Other Income	$_____	$_____
Total	$_____	$_____

Number of members in household (including yourself) _____

_____ _____
Signature Date

Clinic Use Only (upon verification of above information):

Adjustment: $_____

Adjusted (new) fee: $_____

_____ _____
UT Hearing & Speech Center Representative Date

Documentation of household income is required. Please provide proof of income as listed on attached sheet.