Magnolia Midwifery LLC
BIRTH | WELLNESS | EDUCATION

Surplus fee Application

Pregnant people have the right to compassionate midwifery care. The sliding scale from my ongoing commitment to increase accessibility to midwifery care and homebirth. This information is confidential and bears no influence on the quality of care you will receive.

A surplus fee is offered based on family size and monthly resources for nine months and anticipated changes in the next 9 months. Please complete the following information and return by email to determine if you are eligible.

This information is private and is not shared within the practice or externally.

Name:		
Occupation:	**City:**	**State:**

Relationship Status:

o Single
o Widowed
o Married
o Partnered
o Divorced
o Legally separated
o Registered Domestic Partner
o Other: _____

o Living together o Living separate o Other: _____

Earned Income: Please list your, your partner, and others who contribute to your household incomes. Also please list the number of dependents under age 18. Include average monthly income for the last nine months. [Total income for 9 months ÷ 9 = Average income]

Number of dependents < 18 years old				
Income*	**Self**	**Partner/Spouse**	**Other**	**Total**
Average Monthly				
Total last 9 months				

*Income sources: Gross wages, salaries, tips, etc., Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension, or retirement income

Unearned Income and Resources: How else are you meeting monthly expenses? What contributes to your financial safety net? (i.e. student loans, family gifts, borrowed money, trust funds, savings, etc.) _____

_____

_____

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Anticipated changes in income and resources in the next 9 months (new employment, gifts, loans, etc.): _____

_____

_____

The scale used to determine your payment is based on your percent of earned and unearned income level compared to the federal poverty level. The scale is updated during the first quarter of every calendar year with the latest federal poverty guidelines.

I certify that the family size and income information shown above, and additional documents (if requested) are correct and a true representation of my financial resources.

Client Name: (Print) _____

Client Signature: _____ Date: _____

Partner Name: (Print) _____

Partner Signature: _____ Date: _____

***Donations are also welcomed to increase my ability to offer midwifery and homebirth services to those who cannot meet the actual cost of services. Donations are not tax deductible.**

Office Use Only

Client Name:	
Surplus Sliding Scale Level:	
Surplus Sliding Scale fee %:	
Approved by:	Date:

Verification checklist

- ☐ Income: prior year tax return
- ☐ Three months proof of total household income
  - _____
  - _____
  - _____
  - _____