

CHART # _____

Date Received _____

**Family Health Center
Application for Sliding Fee Program**

Applicant Name (please print) _____ DOB: _____

SSN: _____

Address (please print) _____ City _____ State _____ Zip _____

Phone # _____ Additional Phone # _____

Reason for Applying

I have no medical insurance _____

I have medical insurance with a deductible over \$500/per year _____

Please provide your current insurance card.

Number of people in household _____ Adults _____ Children _____

Names of household members that are also patients here.

NAME	DATE OF BIRTH	RELATIONSHIP	MRN #

Sources of Income for HOUSEHOLD (Circle YES or NO)

Employed? (YES / NO) Please provide 2 current pay-stubs for **EACH** person and **EACH** job.

Hire Date _____

Please check how often are you paid? Weekly _____ Biweekly _____ Monthly _____

Social Security? (YES / NO) Please provide benefit letter.

Child Support? (YES / NO) Please provide court order or CSE printout.

Retirement/Pension? (YES / NO) Please provide documentation.

Unemployment Income? (YES / NO) Please provide 2 check stubs.

If you have none of the sources of income listed above, please provide your food stamp letter to verify income for our grant.

By signing this form, I verify that the above information is true to the best of my knowledge. I agree to pay my portion of the charges at the time of each visit. There is a **MINIMUM** charge of \$20 at each visit. I also understand that labs and vaccines may be an additional charge. If my income changes, I will notify Family Health Center of these changes.

Signature of Applicant _____

Date _____

Reserved for FHC Staff

Annual income calculation: _____ Sliding Fee Level _____ FHC employee _____

Audit Comments: _____ Audit employee _____