Sliding Fee Application

Household Information- Patient Name:_______________________________**DOB**______________

Name of Spouse: ____

Number of Adults in the home: ____

What is your income per pay period? ___________

Name of children less than 18 years of age in the home-

Name:____**DOB**_______________________

Name:____**DOB**_______________________

Name:____**DOB**_______________________

General Information about the Applicant-

Have you ever applied for Medicaid? Y or N

Have you ever applied for Medicare? Y or N

If denied Medicaid /Medicare , please list the reason:

Do you have private health insurance? Y or N If yes, name of insurance: _________________________

Have you applied for disability? Y or N **Were you denied disability income?** Y or N

Are you currently working? Y or N **If no, are you on unemployment?**

Are you disabled? Y or N **Do you live in homeless shelter?** Y or N

Are you pregnant? Y or N **Are you a minor student?** Y or N

Proof of Income- Please circle what proof of income you have.

Recent Income Tax Return Food Stamp Verification Cash Assistance Letter W 2 Current Pay Stubs

Social Security/Disability Child Support Letter

Applicant Statement:

I have completed this application for the sliding fee eligibility and confirm that all information is correct to the best of my knowledge. I also understand a minimum payment of $15 to $45 based on my income and family size will be requested at the time of each medical visit. No sliding fee application will be accepted 90 days after date of service.

Applicant Signature:____**Date:** ___________________

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Annual Gross Income:

For Office Use Only

Application Approved For: ( ) 0-100% Copay $15 ( ) 101-150% Copay $25 ( ) 151-175% Copay $35 ( )176-200% Copay $45 ( ) 201% or over Application Denied- Responsible for 100% of bill

Proof of Income is attached to application? (Circle) Y or N

Approved by FCHC Staff- Name:____**Date:** ____________________

This form must be updated March 1 every year. Rev. 3/2021