PROMISE COMMUNITY HEALTH CENTER

SLIDING FEE APPLICATION

The Sliding Fee Scale is a method for providing reduced fees, based on a household's size and income. In order to be eligible for this program, the following application must be completed, signed, dated and submitted to the Care Coordinator, along with **paystubs from the last 30 days for all the people in the household or last year's Income Tax Return.**

Head of Household: Last_____First_____Phone_____
Mailing Address: _____City_____State_____Zip code_____

Sources of Income: All members living in the household. "Household" are considered all persons living with you at the same address. If living situation is temporary, please advise PCHC Staff of your situation.

Source	Amount	Weekly	Bi-Weekly	Monthly	Annually
Salaries and Wages (self)	_____	[ ]	[ ]	[ ]	[ ]
Salaries and Wages (spouse)	_____	[ ]	[ ]	[ ]	[ ]
Salaries and Wages (other)	_____	[ ]	[ ]	[ ]	[ ]
Workmen's Comp (SIIS)	_____	[ ]	[ ]	[ ]	[ ]
Social Security (Self/Spouse)	_____	[ ]	[ ]	[ ]	[ ]
Social Security (Children)	_____	[ ]	[ ]	[ ]	[ ]
SSI (Supplemental Security)	_____	[ ]	[ ]	[ ]	[ ]
Child Support/Alimony	_____	[ ]	[ ]	[ ]	[ ]
Military/Veteran Benefits	_____	[ ]	[ ]	[ ]	[ ]
Unemployment Benefits	_____	[ ]	[ ]	[ ]	[ ]
Other Family Members	_____	[ ]	[ ]	[ ]	[ ]

Household size: List all household members by NAME, DATE OF BIRTH AND RELATIONSHIP, include yourself:

NAME	DATE OF BIRTH	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE READ THE FOLLOWING CAREFULLY!!

I, the undersigned, have completed this application for Sliding Fee eligibility and confirm that this information is true and correct, to the best of my knowledge. I understand that any change in financial status or the number of people in my household must be reported to Promise Community Health Center and a new application must be completed. I further understand that, upon request there will be an annual review of my application with the possibility of changes. I understand any falsifications or the failure to report any changes may result in my being made ineligible for the Sliding Fee adjustments made available by Promise Community Health Center.

Applicant's Signature_____Date_____