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 receptionist, along with **proof of income (see listing on back side for acceptable forms of income)**

Head of Household: Last_____ First _____ Phone _____
Mailing Address: _____ City _____ State _____Zip _____

Have you or any of your household members applied for Medicaid (Title XIX)? Yes □ No □

SOURCES OF INCOME: All members living in the household. "Household" is considered all persons living with you at the same address. If living situation is temporary, please advise Promise staff of your situation.

Source	**Amount ($)**	**Weekly**	**Bi-Weekly**	**Monthly**	**Annually**	**Staff Notes:**
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 / Veterans Benefits		□	□	□	□	
Unemployment Benefits		□	□	□	□	
Other Family Members		□	□	□	□	

HOUSEHOLD SIZE: List all household members by NAME, DATE OF BIRTH, AND SOCIAL SECURITY NUMBER, include yourself:

NAME	**DATE of BIRTH**	**RELATIONSHIP**	**SOCIAL SECURITY #**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE READ THE FOLLOWING CAREFULLY

I declare that my household's financial status is as listed above. I understand the following:

- Promise CHC is utilizing federal tax dollars to assist me in receiving health care
- Giving false information regarding my household income is considered fraud against the U.S. government
- Any change in my finances or the number of people in my household must be reported to Promise CHC and a new application must be completed

Applicant's Signature _____ Date _____

You are required to provide proof of listed income in order to complete your application. The following are acceptable forms of income:

- Current Federal Income Tax (1040-1040 EZ Form)
- Paystubs for recent month
- Current bank statement showing direct deposit (SS, SSI, SSD, Fip, Child support)
- Printout from office issuing payments (SS, SSI, SSD, unemployment, VA, etc)
- Pension payments, Veteran's Benefits
- Court order for alimony or child support or printout for child support payments
- Employer statement for cash wages (must include employer name, address and phone number)
- Award letter
- Letter from caregiver

Office Use Only:

Guarantor #: _____

Application Received/Entered: Date: _____ By: _____

	Yes	N/A	Notes:
Has patient or any household members applied for Medicaid/Medicare/other assistance?	☐	☐	
Unemployment Declaration Completed?	☐	☐	
Self-Declaration of Income Completed?	☐	☐	

Calculated Income Total: $_____ Household Size: _____

Sliding Fee Scale Level Approved: A B C D E

Family Planning SFS Level Approved: A B C D E

Reviewed for past dates of service for adjustments: ☐ Yes ☐ N/A By: _____

Patient Notified of SFS Application Status:

☐ At office/in person ☐ Reached patient by phone ☐ Attempted by phone/didn't reach patient

Date: _____