Sliding Fee Application

The Sliding Fee Discount Program is a federal program that permits to Family Health Matters (FHM) to discount normal charges for all services provided within FHM scope of project. Eligibility is based on income and family size only. In order to be eligible for the Sliding Fee Scale, you must provide accurate and acceptable proof of income as well as list all family members. You must report any changes in family income or number of members in the household when these changes occur. Information must be updated every twelve (12) months or with any change of household income or household size.

The Patient Information

Patient name: _____ Date of birth: _____

Home address: _____

Phone number: (_____) _____-_____ Social Security Number: _____-_____-_____

Do you have medical Insurance? [ ] Yes [ ] No

Income Information

Name:	Income	Frequency (Circle one)	Employer/Origin
You:	$	Weekly Bi Weekly Monthly Annually	
Spouse:	$	Weekly Bi Weekly Monthly Annually	
Child:	$	Weekly Bi Weekly Monthly Annually	
Child:	$	Weekly Bi Weekly Monthly Annually	
Other:	$	Weekly Bi Weekly Monthly Annually	

Other Income	You	Spouse	Child	Child	Total:
Social Security Income					$
Public Assistance					$
Retirement Income					$
Unemployment Income					$
Child Support/ Alimony					$
Other					$
				Total:	$

- ☐ I declare I have worked and received payment in the amount of $_____per
  (Select one) [ ] Day [ ] Week [ ] Two Weeks [ ] Month

- ☐ I declare that I do not have a pay stub or other documentation that proves my income.
- ☐ I declare that I am not employed and do not have income of any kind.
- ☐ I attest that all information that I have provided is true, complete, and may be verified.

Household size

Please list all individuals living in your household, including yourself.

Name	Date of birth	Social Security Number

I affirm that the information in this application is true and correct to the best of my knowledge. I understand that providing false information or failing to report income or a change in the income may disqualify me from being considered to receive discounted medical services available at Family Health Matters Community Health Center and may result in penalties under federal law including fines and jail time. If I qualify for the sliding fee discount program, I will comply with all rules and regulations set forth by Family Health Matters Community Health Center. I affirm that I have read and understand all terms and conditions.

_____ _____

Patient Signature Date

Witness:

I am witness that this patient cannot provide documentation of income:

Name: _____ Signature: _____ Date: ___/___/_____