



SLIDING FEE DISCOUNT PROGRAM

APPLICATION

INSTRUCTIONS

1. In order to receive discounted services, all patients must apply annually for the Sliding Fee Discount Program. Eligibility is based on family size and household income, as it relates to current Federal Poverty Guidelines.
2. Please read the *Sliding Fee Discount Program Information* sheet. If you have additional questions, please ask the front desk.
3. Please fill out the application and return it to Neighborhood Health Center (NHC) with proof of income attached. Don't forget to sign and date your application.
4. If you can't attach proof of income to your application today, please return proof of income to NHC within 30 days of submitting this application.
5. List yourself as the first family member, followed by others. For individuals not earning an income (for example, a child within your family), enter zero (\$0) for their monthly income.

PERSONAL INFORMATION

Full Name	
Address	
Phone Number	
Today's Date	

FAMILY MEMBERS

Full Name	Date of Birth	Relationship	Monthly Income (before taxes)
		Self	\$
			\$
			\$
			\$
			\$
			\$
			\$

IF YOU REPORT ZERO FAMILY INCOME OR A SOURCE OF INCOME THAT CANNOT BE PROVED

How long have you been without a taxable source of income?	<input type="checkbox"/> > 6 months <input type="checkbox"/> 6 months-1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> Over 2 years
Why are you unable to provide proof of income?	

SEE OTHER SIDE FOR ATTESTATIONS AND SIGNATURE

ATTESTATIONS

Please read and initial next to each attestation

	I attest that I have read the <i>Sliding Fee Discount Program Information</i> sheet and understand requirements to participate in the program.
	I understand that discount will not be applied until my application <u>and</u> proof of income are reviewed and accepted by NHC. I understand that if I cannot provide proof of income, discount will not be applied until my request to waive proof of income is reviewed and approved by NHC's Chief Operating Officer or their designee.
	I understand that eligibility in the program is valid one year from the date my application is approved. I understand I must reapply each year to remain in the program.
	I understand that should my income or family size change during my one-year period of eligibility, I will report changes to NHC and reapply for the program.
	I understand that should my insurance prohibit a waiver of my co-pay, the full co-pay will be collected at the time of service. If you are unsure, contact your insurance company.

SIGNATURE

I certify that the information stated is true and accurate by signing this form. If false information is used to obtain assistance, I will be removed from the sliding fee discount program.

Applicant Signature	Date



-----**DO NOT WRITE BELOW THIS LINE**-----

OFFICE USE ONLY

Applicant/s Information	
Patient/s MRN	
Monthly Family Income (from table on pg.1)	\$
Family Size (from table on pg.1)	
Proof of Income Status at Time of Application	<input type="checkbox"/> A. Yes, proof attached <input type="checkbox"/> B. Pending, 30-day grace period <input type="checkbox"/> C. No, applicant has listed zero or cash source of income, pending approval by COO or designee
Date	
Reviewed By	

Proof of Income Status: A or B	
Monthly Family Income (verified by proof)	\$
Discount Class	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
Date Verified	
Reviewed By	
Proof of Income Status: C	
Decision	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Discount Class	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E
Date of Review	
Signature of COO or Designee	