Northern Counties Health Care
Application for Sliding Fee Scale

APPLICANT NAME: _____ SS#: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____ TELEPHONE: _____

PLACE OF EMPLOYMENT: _____

PLEASE CIRCLE THE KIND OF INSURANCE YOU HAVE: Commercial Medicare Medicaid Self-Pay

ARE YOU CURRENTLY ELIGIBILE FOR MEDICAID? Yes No Don't know

HOUSEHOLD MEMBERS WHO YOU CLAIM AS A DEPENDENT:

NAME	**DATE OF BIRTH**	**PATIENT AT NCHC**
Spouse: _____	_____	YES NO
Dependent _____	_____	YES NO
Dependent _____	_____	YES NO
Dependent _____	_____	YES NO
Dependent _____	_____	YES NO

TOTAL FAMILY SIZE: _____

ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, veteran's benefits				
Alimony, child support, military family allotments				
Income from business, self employment				
Rent, interest, dividend, and other income				
Public Assistance i.e. welfare assistance, fuel assistance (excluding food stamps)				
TOTAL INCOME				

Proof of all sources of income required at time of application including copies of court orders if applicable.

Employed (one of the following)

- Copy of most recent Income Tax
- Three most recent pay stubs
- Written statement from employer stating hours/week, hourly wage, paid weekly or bi-weekly

Unemployed (All that apply)

- Public Assistance check stub/copy
- Social Security letter of award
- Written Statement of No Income that includes a cosigners signature
- Letter of Declaration from 501 (c)(3) organization such as a Church

(See Over)

PLEASE NOTE:

- Co-pays and deductibles are eligible for the Sliding Fee Scale.
- Patients on the Sliding Fee Scale must re-apply annually in April as Federal Poverty Guidelines change.
- The discount will apply to all services received at our office and for labs done at our affiliated lab. Services purchased from outside agencies will not be discounted, i.e. x-rays.
- If there are special financial circumstances that you would like considered, please ask to speak with either the Practice Manager or Chronic Care Coordinator.

I hereby certify that the above information is true and accurate to the best of my knowledge. I agree to provide any documentation requested and authorize the health center to verify all information provided. **I understand that payment must be paid at the time of the visit or no fee reduction may be offered for that visit.** The minimum payment is $10.00 (medical) and $15.00 (dental). If any information I have given proves to be untrue, I understand that the health center may re-evaluate my financial status and take whatever action becomes appropriate.

_____ _____

Applicant Signature Date

FOR OFFICE USE ONLY:

Denial _____ Approval _____ Rate Reduction _____

Approved/Denied by _____Date: _____

Starting Date _____ Ending Date _____