**Sliding Fee Discount Program Application**

Your healthcare shouldn’t depend upon how much money you have, whether you have insurance or if you have managed to take good care of your health in the past. To keep your healthcare affordable, we proudly offer fees centered around your family size and income. A fully completed application including verification of income must be on file and updated annually.

**REDUCED FEES MAY RANGE FROM $35 TO $50 PER VISIT!**

**PERSONAL INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has patient or household members applied for Medicaid? ***Yes*** ***No***

Has patient or household members applied for Medicare? ***Yes*** ***No***

Has patient or household members applied for other assistance? ***Yes*** ***No***

**HOUSEHOLD SIZE INFORMATION** – Patient, Spouse, Children under age 19, Children age 19-23 claimed on the tax return, children over age

19 that are permanently disabled and the patient provides more than half of child’s support.

|  |  |
| --- | --- |
| 1. Name/Relationship Age | 2. Name/Relationship Age |
| 3. Name/Relationship Age | 4. Name/Relationship Age |
| 5. Name/Relationship Age | 6. Name/Relationship Age |
| 7. Name/Relationship Age | 8. Name/Relationship Age |

**INCOME SUMMARY TABLE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sources** | **Amount ($)** | **Weekly** | **Bi-Weekly** | **Monthly** | **Accepted Documents** |
| Wages (Self) |  |  |  |  | One month of paycheck stubs. |
| Wages (Spouse) |  |  |  |  | One month of paycheck stubs. |
| Wages (Other) |  |  |  |  | One month of paycheck stubs. |
| Social Security |  |  |  |  | Award letter(s) listing amount received. |
| Supplemental Security |  |  |  |  | Award letter(s) listing amount received. |
| Social Security (Children) |  |  |  |  | Award letter(s) listing amount received. |
| Worker’s Compensation |  |  |  |  | Worker’s compensation benefit award letter for the current year. |
| Unemployment Compensation |  |  |  |  | Unemployment compensation benefit award letter. |
| Child Support, Alimony |  |  |  |  | Divorce decree stating child support or alimony received. |
| Veteran’s Payments |  |  |  |  | Letter supplied by veterans administration with benefit amount. |
| Retirement Income |  |  |  |  | Pension or 401K statement |
| Self-Employed |  |  |  |  | Tax return with Schedule “C” gross income |
| Other Income (Specify) |  |  |  |  | Statement from family or friends explaining financial assistance. |
| **TOTAL** |  |  |  |  |  |

**SELF-DECLARATION OF INCOME** – Please provide as much information as possible as to why you cannot provide proof of any income. I.e. worked odd jobs for cash; started new business…..

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that all of the information given may be confirmed by Christ Health. I also understand that providing false information is considered fraud and will result in a denial of the Sliding Fee Scale Program application and that I will be responsible for the payment of charges for the services provided. I also understand a nominal fee will be required at the time of each office visit in addition to any applicable fees.

Applicant Signature (required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_