Sliding Fee Discount Program Application

To help make healthcare affordable, we offer a sliding fee based on family size and household income. This fully completed application and income verification documentation must be on file with Christ Health, and updated annually. **You must provide poof of income for all members of your household in order to qualify for a discounted fee.**

Fees will vary depending on the service type and procedure, and will be discounted based on your eligiblity for the Sliding Fee Discount Program.

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- include income for everyone in your household*

Sources	Amount ($)	Weekly	Bi-Weekly	Monthly	Accepted Documents
Wages (Self)					A paycheck stub from the past 4 weeks.
Wages (Spouse)					A paycheck stub from the past 4 weeks.
Wages (Other)					A paycheck stub from the past 4 weeks.
Social Security (for you or spouse)					Award letter(s) listing amount received.
Disability/Supplemental Security Income (SSI) (for you or any household member)					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 (for you or any member of your household)					Unemployment compensation benefit award letter.
Child Support, Alimony					Divorce decree stating child support or alimony received.
Veteran's Payments (for you or any member of your household)					Letter supplied by veterans administration with benefit amount.
Retirement Income (for you or any member of your household)					Pension or 401K statement
Self-Employed income (for you or any member of your household)					Tax return with Schedule "C" gross income
Family/Partner Support					Statement from family, partner or friend explaining financial assistance they provide (ask for "Letter of Support" Form).
Other income (specify)					Documentation of other income (rental property income, annuity payments, etc.)
TOTAL					

***If you do not have any income to report above you should complete the Self-Declaration of No Income form.**

I understand that all of the information given in this Application may be confirmed by Christ Health. I also understand that providing false information is considered fraud and will result in a denial of this Application and that I will be responsible for the payment of charges for the services provided, without any discount or reduction. If my application is approved, I understand that a discounted fee will be required at the time of each visit, in addition to any other fees that apply for additional procedures.

Applicant Signature (required): _____ Date: _____