COASTAL FAMILY HEALTH CENTER

APPLICATION FOR SLIDING FEE DISCOUNT

It is the policy of Coastal Family Health Center, Inc., to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information to determine if you or members of your family are eligible for a discount.

This form must be completed annually to re-evaluate your eligibility.

PATIENT INFORMATION	
NAME	PATIENT ID#
Number of people living in your household: _____	Total Income before deduction: $_____

HOUSEHOLD INFORMATION					
Name of Household Member	**Relationship**	**Birth Date**	**Weekly Income**	**Monthly Income**	**Yearly Income**
1.	Self				
2.					
3.					
4.					
5.					
6.					
7.					
8.					
Total					
				Slide Level for Payment:_____% of charge	

VERIFICATION CHECKLIST: **Office Use Only**

Required Document	**Yes**	**No**
1. Proof of Identification/Address: Driver's license, birth certificate, employment ID, social security card, and other		
2. Proof of Income: • Prior year tax return, recent pay stubs, pensions, social security benefits, disability, veteran's benefits, unemployment compensation, retirement, child support or alimony payments, letter with balance on Electronic Benefit Transfer (EBT) card, or reference letter to verify unemployment status • If income is paid in cash, please provide a letter from employer to include the current date, date hired, employee's name and address, employer's name/address/phone number, wages per hour and how many hours of work per week, and frequency of pay period. The letter must be signed and dated by the employee and employer.		
FOR PATIENT WITH INSURANCE		
• **Insurance:** Health and/or dental insurance, prescription coverage, supplement insurance card		
• **Medicaid:** Medicaid card		
• **Medicare:** Medicare card		

I hereby certify that the information shown above is correct, and understand that verification is required for approval. Also, I understand that I must provide this information at least yearly to receive slide fee discounts for services. Any false statements, documents or concealment of a material fact will disqualify me from receiving sliding fee discounts.

I understand that if I am applying for financial assistance and do not have proof of income with me today, I will be responsible for 100% of my services today at Coastal Family Health Center. I will also be responsible for 100% charge at any subsequent visits until I provide proof of income.

_____ _____

Name (Print) Signature/Date