MY COMMUNITY HEALTH CENTER

Sliding Fee Application

Personal Information

Name:_____

Date of Birth:_____ Social Security Number:_____

Address:_____

Home Phone Number:_____ Cell Number:_____

Household Information

Household is defined as people related by birth, marriage/significant other or adoption and residing together. The household size will be limited to immediate family: spouse, partner, children/dependents and grandparents (if applicable). Dependents must be age 21 or younger

Name of Spouse:_____ Date of Birth:_____

Social Security Number:_____

List of dependents claimed on your tax return:

Name	Social Security Number	Date of Birth	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Proof of Income

One of the following must be provider for proof of income to process this application. Until the application and information is provided the patient will be responsible for the entire amount of services provided.

- ☐ Most Recent Tax Return
- ☐ Last 3-4 Paystubs from each member of household
- ☐ Unemployment Award Letter
- ☐ SS/Disability Award Letter
- ☐ Other documented incomes such as Alimony/Child Support, public assistance, veterans payments, survival benefits, pension/retirement, or other miscellaneous income. Food stamps and housing subsides do not count. Gross income means the patient's household income before taxes or other deductions
- ☐ If there is no income – a letter must be provided from someone outside the home on how the patient's basic needs are met.

PATIENT SIGNATURE:_____

APPROVAL:

Annual Gross Income:_____ Household Size_____ Valid dates_____

Application Approved ☐ Slide 1 ☐ Slide 2 ☐ Slide 3 ☐ Slide 4 ☐ Slide 5

☐ Full Amount ☐ Denied - Reason_____

Processed by:_____ Date:_____

MY COMMUNITY HEALTH CENTER

My Community Health Center Sliding Fee Scale:

To support our mission to provide care to all regardless of ability to pay we have established a sliding fee scale. This provides a schedule of fees and payment options to the uninsured and underinsured patients in the community we serve. The schedule of fees is called the Sliding Fee Discount Program (SFDP). This schedule applies to services offered at My Community Health Center.

The Sliding Fee Discount Program (SFDP) will be offered to eligible persons based on the client's ability to pay. Ability to pay is determined by the household size and annual gross income relative to the most recent U.S. Department of Health & Human Services Federal Poverty Guidelines (FPG). The SFDP income guidelines are updated annually and based on the FPG as published in the Federal Register.

My Community Health Center's SFDP applies to services offered at My Community Health Center. The Health center has negotiated rates for your other services which are provided by other health care providers, such as lab, pharmacy, dental and radiology.

In order to determine your eligibility for the SFDP, you must complete the application in its entirety and proved the required documentation. Failure to do so will result in full responsibility of all charges.