Sliding Fee Discount Schedule Program Application

Patient Information			**Today's Date: / /**	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Cell Phone #: ( )		
Date of Birth: / /	Social Security # Last Four Only -		Do you have insurance? (circle one)	Yes No

Note: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Your yearly income W-2 form, paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

By signing below, you authorize RUHS-Community Health Center to verify your information related to income and family size.

Other Household Members	Relationship	Date of Birth	Social Security Number
		/ /	Last Four Only -
		/ /	Last Four Only -
		/ /	Last Four Only -
		/ /	Last Four Only -
		/ /	Last Four Only -
		/ /	Last Four Only -
		/ /	Last Four Only -

Household Income				
Person	**Amount**	**Frequency (Circle one)**	**Employer:**	**Employer Address**
You	$	Weekly Monthly Yearly		
Spouse	$	Weekly Monthly Yearly		
Children	$	Weekly Monthly Yearly		
Other	$	Weekly Monthly Yearly		
TOTAL	**$**	**Weekly Monthly Yearly**		

Other Income - List	You	Spouse	Children	Other	Subtotal
				TOTAL	**$**

Does this SFDS Program help to reduce the cost barrier to health care for you? Yes No (circle one)

If you are placed in Slide Category A, is the Nominal Fee a hardship for you to pay? Yes No (circle one)

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the Sliding Fee Discount Schedule Program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform RUHS-Community Health Center there is a significant change in my income. If acceptance to the Sliding Fee Discount Schedule Program is obtained under this application, I will comply with all rules and regulations of RUHS-Community Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_____ Signature (Patient/Parent/Guardian):_____

Form Revised 06/15/2018