Fordland Clinic: Sliding Fee Application

Because we are a Community Health Center, we have the opportunity to offer a discount on your services based on your annual income. If you feel this may be a benefit to you and your family, you will need to complete the Sliding Fee Scale program application and provide verification of income.

Head of Household Information

Name: (First, middle initial, Last):	Social Security Number	Date of birth:	County:
Address:	City/State/Zip:	Home phone:	Work phone:
# of people being supported in the home:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		

Income Information: Please complete for all adult household members who are employed

Employed Person	Company Name	Income (before taxes)	Paid how often? (check one)
			☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
			☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
Other sources of income	Alimony $	TANF $	Pension/Retirement $
Child Support $	Disability $	S.S.I $	Social Security $
Unemployment $	Other $	Other $	Other $

PROOF OF INCOME MUST BE PROVIDED TO FC - OTHERWISE, SERVICES WILL BE RENDERED AT CUSTOMARY PRICE.

Mandatory Proof of Income: Previous year's income tax return. If no tax return filed, please complete IRS Form 4506-T.

If no tax return available, other forms of income accepted are: most recent three paystubs, most recent three bank statements, SSI/Disability letter, Food Stamp letter, Unemployment benefits letter

If your income is $0, how are you meeting your food, clothing, shelter and transportation needs?

_____

Household Information: List ALL individuals in household, including head of household – Use back side of form if needed

Name	DOB	Relationship	Age	Income	Employed
				$	Yes / No
				$	Yes / No
				$	Yes / No
				$	Yes / No
				$	Yes / No

By signing below, I agree that the Fordland Clinic staff may contact each employer listed and or other agencies to confirm my income. I will provide FC with proof of income for the purpose of calculating my discount. I will be asked to re-affirm on an annual basis. I agree to inform FC if there are changes to my income, household size or insurance coverage. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of services. I hereby certify that the information I provide is correct.

Applicant Signature: _____ Date:_____

Guardian or Power of Attorney Signature:_____ Date:_____

Please make sure that you include your proof of income with this application

For internal use only

Account #	
Effect Date	
Total Income	
Slide Level	