



Community Health Services

Sliding Fee Scale Application Valid from April 1, 2010 through March 31, 2011

Please fill out the application completely and attach all income information. Adjustments will go back 60 days from the date the application is approved.

PERSONAL INFORMATION

Last Name: _____ First Name: _____
 Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____
 Home Address: _____

 Phone Number: (Home) (____) ____ - ____
 City/State _____ Zip _____ Phone Number: (Cell) (____) ____ - ____

HOUSEHOLD INFORMATION

Name of Spouse: _____
 Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____

List Dependents under the age of 18

Name	Social Security No.	Date of Birth	Relationship
_____	____ - ____ - ____	____ / ____ / ____	_____
_____	____ - ____ - ____	____ / ____ / ____	_____
_____	____ - ____ - ____	____ / ____ / ____	_____
_____	____ - ____ - ____	____ / ____ / ____	_____
_____	____ - ____ - ____	____ / ____ / ____	_____

PROOF OF INCOME

You must bring proof of income. () Most Recent Income Tax Return () Form 4506-T
 () Social Security/Disability

I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge. ***I also understand a minimum payment of \$20.00 will be requested at the time of each medical office visit and a \$25.00 minimum payment will be requested at the time of each dental office visit.***

Applicants Signature

Date

ELIGIBILITY INFORMATION - FOR OFFICE USE ONLY

Annual Gross Income \$ _____ Number of Dependents _____

Application Approved () 20% Payment (A) () 40% Payment (B)
 () 60% Payment (C) () 80% Payment (D)

Application Denied - RESPONSIBLE FOR 100% OF BILL

Processed By

Date