Community Health Services

410 Birchard Avenue * Fremont, Ohio 43420

Sliding Fee Scale Application
Valid from April 1, 2009 through March 31, 2010

Please fill out the application completely and attach all income information. Discounts will go back 60 days from the date that 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