



# Community Health Services

Your Partners for Better Health

## Sliding Fee Scale Application

Valid to March 31, 2018

### 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 claimed on your tax return:

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

- I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge.

**- I understand a nominal fee of \$25.00 will be requested at the time of each medical office visit and a \$30.00 nominal fee will be requested at the time of each dental office visit and will be responsible for any remaining balance.**

- Sliding fee adjustments will go back 60 days from the date the application is approved.

\_\_\_\_\_  
Applicants Signature

\_\_\_\_\_  
Date

### ELIGIBILITY INFORMATION - FOR OFFICE USE ONLY

Annual Gross Income \$ \_\_\_\_\_ Number of Dependents \_\_\_\_\_

Application Approved ( ) Nominal Fee Only ( ) 20% Payment ( ) 40% Payment  
 ( ) 60% Payment ( ) 80% Payment

Application Denied - RESPONSIBLE FOR 100% OF BILL

\_\_\_\_\_  
Processed By

\_\_\_\_\_  
Date