CHS Community Health Services
Your Partners for Better Health

Sliding Fee Scale Application

Valid to March 31, 2020

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