Community Health Services
Your Partners for Better Health

Valid to March 31, 2022

SLIDING FEE SCALE APPLICATION

PERSONAL INFORMATION

LAST NAME ______ FIRST NAME ______

DATE OF BIRTH ______ SOCIAL SECURITY NUMBER ______

ADDRESS – CITY, STATE & ZIP ______

HOME PHONE NUMBER ______ CELL PHONE NUMBER ______

HOUSEHOLD INFORMATION

NAME OF SPOUSE ______

DATE OF BIRTH ______ SOCIAL SECURITY NUMBER ______

LIST DEPENDENTS CLAIMED ON YOUR TAX RETURN

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP
NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP
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NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP

PROOF OF INCOME

You must bring proof on income. ☐ Most recent 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 $30.00 will be requested at the time of each medical office visit, a $35.00 nominal fee will be requested at the time of each dental office visit, and a $10.00 nominal fee for each behavioral health office visit, and that I will be responsible for any remaining balance.***
- Sliding fee adjustments will go back 60 days from the date the application is approved.

APPLICANT'S SIGNATURE ______ DATE ______

Eligibility Information – For Office Use Only Annual Gross Income $______ # 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 ______