HIGH COUNTRY community health

Application for Medical Sliding Fee Scale

An application for each household is required every 12 months.

Date: _____Patient Name: _____

Please include all of the following sources of income for the last 12 months for each household member. (Household members who currently live together and share income and expenses.)

All Employment
SSI Disability
WorkFirst (TANF)
Veteran Benefit
Alimony payments
Retirement Income
Social Security Income
Unemployment
Child Support Payments
Any other Income

OFFICE: OFFICE:

Name	Date of Birth	Relationship to Patient	Source of Income	Gross Income Before Taxes	Pay Frequency	Front Desk Calculated Annual Amount	Front Desk Source of Verification

I certify that the income information given to High Country community Health from me is correct and accurate. Please initial the following:

_____ Sliding Fee Scale eligibility takes effect for all services provided today until 12 months from today. I understand I will need to reapply for the sliding fee scale 12 months from today.

_____ I agree to notify High Country Community Health immediately if my contact or income information changes.

High Country Community Health will not refuse care based on inability to pay.

Responsible Party Signature: _____ Date: _____

Staff Signature: _____ Date: _____

STAFF USE ONLY					
	Household Size:	Annual Gross Income:			
Verified Income:	0 – 100% FPL	101 – 125% FPL	126 – 150% FPL	151 – 200% FPL	>201% FPL

Staff: Please include income calculations in the margin of this form or on separate sheet of paper and scan it into the patients records with all income verification.