Sliding Fee Application

Household Information- Patient Name:_______________________________DOB______________
Name of Spouse: ____
Number of Adults in the home: ____
What is your income per pay period? _____________
Are you paid: (circle the one that applies) Weekly Biweekly Monthly Yearly

Name of children less than 18 years of age in the home-

Name:____DOB________________________

Name:____DOB________________________

Name:____DOB________________________

Name:____DOB________________________

General Information about the Applicant-
Have you ever applied for Medicaid? Y or N Have you ever applied for Medicare? Y or N
If denied Medicaid /Medicare , please list the reason:____

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Do you have private health insurance? Y or N If yes, name of insurance: __________________________

Have you applied for disability? Y or N Were you denied disability income? Y or N

Are you currently working? Y or N If no, are you on unemployment? Y or N

Are you disabled? Y or N Do you live in homeless shelter? Y or N

Are you pregnant? Y or N Are you a minor student? Y or N

Proof of Income- Please circle what proof of income you have.

Recent Income Tax Return Food Stamp Verification Cash Assistance Letter

Current Pay Stubs Social Security/Disability Child Support Letter

Applicant Statement:

I have completed this application for the sliding fee eligibility and confirm that all information is correct to the best of my knowledge. I also understand a minimum payment of $15 to $45 based on my income and family size will be requested at the time of each medical visit.
Applicant Signature:____Date: ____________________

Eligibility Information- For Office Use Only

Annual Gross Income: $
Application Approved: ( ) 0-100% ( ) 101-150% ( ) 151-175% ( )176-200% ( ) 201% or over

Application Denied- Responsible for 100% of bill

Proof of Income is attached to application? Y or N
Approved by FCHC Staff- Name:____Date: _____________________

This form must be updated at the beginning of every year. Rev. 12/17