PRIORITY HEALTH CARE
A UNIVERSAL APPROACH TO CARE ©

SLIDING FEE SCALE DISCOUNT APPLICATION

As a Federally Qualified Health Center (FQHC), Priority Health Care (PHC) is required to provide a Sliding Fee Scale Discount Program to patients who meet eligibility guidelines. Further, it is the policy of PHC to provide quality health care regardless of the patient's ability to pay.

Discounts are offered based upon household income and size. A Sliding Fee Schedule is used to calculate the basic discount and is updated on an annual basis using the current federal poverty guidelines. Once approved, the discount will be honored up to twelve (12) months, after which the patient must reapply.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services.

Sliding Fee Discounts are determined based upon household size and annual income, regardless of health insurance status.

☐ OPT-IN (YES)	☐ OPT-OUT (NO)
I have been given the opportunity to apply for Priority Health Care's sliding fee scale discount, and **I DO** wish to apply for discounted services at this time. To determine eligibility for the sliding fee program, I must provide valid income and household information.	I have been given the opportunity to apply for Priority Health Care's sliding fee scale discount, and **I DO NOT** wish to apply for discounted services at this time. I understand I will be responsible for all costs not paid by third party insurers. **Patient Signature:** _____ *Complete Section 1 - Demographics*

Section 1 - Demographics

Name of Head of Household _____ **Date** _____

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Phone _____ **Email** _____

Section 2 – Household Composition

Please list all immediate family members and persons living in your household (spouse or life partner and children that are under the age of 21 years) and that are dependent on family income. Please do not include guests, elderly parents, or roommates.

Name	Relationship to Head of Household	Date of Birth	Has Insurance? 'Other' (Please Specify)				
			None	Medicaid	Medicare	Commercial	Other:
	Head of Household		☐	☐	☐	☐	☐ ________
			☐	☐	☐	☐	☐ ________
			☐	☐	☐	☐	☐ ________
			☐	☐	☐	☐	☐ ________
			☐	☐	☐	☐	☐ ________
			☐	☐	☐	☐	☐ ________
			☐	☐	☐	☐	☐ ________

Section 3 – Household Income

Proof of income is required. You must provide the documentation based upon the type of income selected.

Name Of Household Member Receiving Income	How Often Income Received?			Estimated Annual Income	Source of Income										
	Weekly (Gross Income * 52)	**Every Other Week** (Gross Income * 26)	**Monthly** (Gross Income * 12)		Wages And Salary	Self Employed	Unemployment Benefits	Social Security	Child Support / Alimony	Worker's Comp	Veteran's Benefits	Military Pay	Income From Rent	Interest/Dividends/ Royalties	Private Pensions and Annuities
	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Summary Household Information

Total Household Members	Total Household Income

Required Documentation by Type of Income

Wages And Salary
☐ Paycheck Stubs (4 Consecutive Weeks)
☐ Letter From Employer on Company Letterhead, Signed and Dated
☐ Income Tax Return / W2

Self Employed
☐ Signed And Dated Income Tax Return and All Schedules
☐ Records Of Earnings and Expenses

Unemployment Benefits
☐ Award Letter/Certificate
☐ Benefit Check
☐ Correspondence From Dept. Of Labor
☐ Public Assistance

Social Security
☐ Award Letter/Certificate
☐ Benefit Check
☐ Correspondence From Social Security Adm.

Child Support / Alimony
☐ Letter From Person Providing Support
☐ Letter From Court
☐ Child Support/Alimony Check Stub

Worker's Comp
☐ Award Letter
☐ Check Stub

Veteran's Benefits
☐ Award Letter
☐ Benefit Check Stub
☐ Correspondence From Veteran's Adm.

Military Pay
☐ Award Letter
☐ Check Stub

Income From Rent
☐ Letter From Tenant
☐ Check Stub

Interest/Dividends/ Royalties
☐ Statement From Bank, Credit Union, Or Financial Institution
☐ Letter From Broker
☐ Letter From Agent

Private Pensions and Annuities
☐ Statement From Pension/Annuity Section

Section 4 – Patient Acknowledgements

I declare, under penalty of perjury, that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for discounted services.

I hereby acknowledge that I am applying for assistance under a U.S. HRSA funded program and that Title 18 Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States.

Patient, Parent or Guardian Signature **Date**

Patient Name (Please Print)

FOR OFFICE USE ONLY

Patient Name _____

Identity and Residency

Proof of identity/date of birth and residence: you must show one of the documents listed in both categories. Photocopies are acceptable.

Identity/Date of Birth (Select One)		Residency/Home Address (Select One)		Income (Select One or More)	
☐Driver's License ☐Official Government Photo ID ☐Passport ☐Immigration/Naturalization Documents (Photo Required)		☐Official Government ID Card With Address ☐Driver's License Issued within the last 6 Months ☐Utility Bill (Gas, Electric, Cable) ☐Bank Statement ☐Correspondence from a Government Agency ☐Letter/Lease/Rent Receipt from Landlord ☐Property Tax Records or Mortgage Statement		☐Wages And Salary ☐Self Employed ☐Unemployment Benefits ☐Social Security ☐Child Support / Alimony ☐Worker's Comp ☐Veteran's Benefits ☐Military Pay ☐Income From Rent ☐Interest/Dividends/ Royalties ☐Private Pensions and Annuities ☐Self-Declaration of Income	
Verified	☐Yes ☐No	**Verified**	☐Yes ☐No	**Verified**	☐Yes ☐No
Date		**Date**		**Date**	

Sliding Fee Scale Decision

This applicant is: ☐ Eligible for Sliding Scale Discount ___ ☐ Not Eligible for Sliding Scale Discount

Approval Date: _____ **Termination date:** _____

Certified By: _____ _____
Staff Name **Date**

Patient Notification

Method	Date	Staff Name
☐Verbal ☐Patient Portal ☐Mail		

Revenue Cycle Notification

Method	Date	Staff Name
☐Email		