SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name	**MRN:**	**Today's Date** (month/day/year)

You must provide proof of income for every adult household member. Examples: a copy of the most recent tax return, your two most current pay stubs, most recent W2's, etc. You must submit documentation within 10 days of your application date.

Name	Relationship	Age	Income Amount	# Hours Worked (per week)	Pay Frequency
	self				❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income

Do you have any other sources of income not listed above? If yes, please provide:
(unemployment, disability/workers comp, social security, pensions, public assistance, etc…) $_____
(monthly)

Total Number of People in Your Household:
(include yourself/spouse, children, and any taxable dependent relatives living with you) _____

I hereby request Elica Health Centers to determine my eligibility for the sliding fee program based on the information I have submitted. I also understand that if the information which I submit is determined to be false, I will be liable for all services at full charge. In signing this application, I affirm that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Elica Health Centers of all changes to my insurance information. Should I fail to do so, payment in full for all services will be my responsibility.

Signature: _____ Date: _____

VERIFICATION AND DETERMINATION (Office Use Only)

1. Household Income verified: ❒ Yes ❒ No (Patient will provide) ❒ No (Self-Declaration Form)
2. If "No," Date documents due: _____. Date documents provided: _____.
3. SFDP Level: ❒ Slide A (< 100%) ❒ Slide B (101 - 124%) ❒ Slide C (125 - 149%)
   ❒ Slide D (150 - 174%) ❒ Slide E (175 - 200%) ❒ Full Fee (> 200%)
4. SFDP Expires: _____

Verified by: _____ Date: _____

Social Care Referral: ❒ Yes ❒ No Date: _____