SLIDING FEE DISCOUNT PROGRAM APPLICATION

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

☐ **I decline to participate in Sliding Fee** Initial & Date: _____

You must provide proof of income for every adult in the household. Examples: a copy of the most recent tax return, two most current pay stubs, most recent W-2s, 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 ❒ Monthly Income ❒ Annual Income
					❒ Hourly Wage ❒ Monthly Income ❒ Annual Income-
					❒ Hourly Wage ❒ Monthly Income ❒ Annual Income
					❒ Hourly Wage ❒ Monthly Income ❒ Annual Income
					❒ Hourly Wage ❒ Monthly Income ❒ Annual Income
					❒ Hourly Wage ❒ Monthly Income ❒ Annual Income
					❒ Hourly Wage ❒ Monthly Income ❒ Annual Income
					❒ Hourly Wage ❒ Monthly Income ❒ 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 (>100 - 125%) ❒ Slide C (>125 - 150%)
   ❒ Slide D (>150 - 175%) ❒ Slide E (>175 - 200%) ❒ Full Fee (> 200%)
4. SFDP Expires: _____

Verified by: _____ Date: _____

Social Care Referral: ❒ Yes ❒ No Date: _____