☐ INITIAL
☐ RE-ASSESSMENT

Friends of Family Health Center

APPLICATION FOR SLIDING FEE RATE

It is Friends of Family Health Center's policy to provide essential and quality services regardless of a patient's ability to pay. Our sliding fee schedule is dependent on family size and gross income. Please complete the following information and return this form to the front desk to determine the sliding fee rate for your visit.

- The sliding fee will apply to all services received at the health center, but not those services which are purchased from third party vendors such as; laboratory testing, prescription drugs, x-ray interpretation by a consulting radiologist, and other similar services.
- Copies of your and your family's tax returns, paycheck stubs, and other information may be required to verify your income before a sliding fee rate is approved.
- The sliding fee applies only to services received from the day your application is approved until the date it is due for re-assessment.
- This form is valid for 12 months from the date you complete it. After 12 months you may complete a Re-assessment Application for Sliding Fee Form.

# of people in your household (including yourself): _____

Total household income (include yourself, spouses, children, etc.):

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi-weekly
Self			
Spouse			
Relatives			
Total			

I certify that the family size and income information shown above is correct. I understand that copies of tax returns, paycheck stubs, and other information may be required to verify the income above before a sliding fee rate is approved. I understand that I will be asked to submit a new application in 12 months when my approved sliding fee rate expires.

_____ _____

Name (Print) Signature

_____

Today's Date