☐ INITIAL
☐ RE-ASSESSMENT

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.

Examples of income include the following:

- Wages from employment (including commissions, tips, bonuses, fees, etc.)
- Income from the operation of a business
- Rental income from real estate or personal property
- Interest or dividends from assets
- Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits
- Unemployment or disability benefits
- Public assistance payments
- Periodic allowances such as alimony, child support, or gifts received from people not living in my household
- Sales from self-employed resources (Avon, Mary Kay, Pampered Chef, etc.) or social media/influencer accounts (Instagram, TikTok, YouTube, Facebook)
- Any other sources not named above

How many people are in your household including yourself (enter a number): # __________

Instructions: Enter the monthly income for each member of your household that you listed above, including yourself.

Household Member	List Full Name	Monthly Income
Self		$
Spouse		$
Relative		$
Relative		$
Other		$

OFFICE USE ONLY

Total income combined for all household members: $ ______________

MRN: ________________________	*FPL % :* ______________
DOB: ________________________	*SFS Rate Determination: $* ______________

☐ Check here if you do not have any documentation to support your proof of income today.

By checking off this box, I am declaring that I do not have any documentation to support my proof of income today for the following reasons: ____.

Office Use Only: Staff Initials ________________

- 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.
- It is your responsibility to update FOFHC if you have a change in family/household size and/or income and at that time, complete a new Application for Sliding Fee Rate.

INITIAL:

________ I understand that copies of tax returns, paycheck stubs, and other information may be required to verify the income amount provided 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 and that I will be asked again to provide documentation regarding my proof of income.

________ I am certifying that the income and family size provided today is the most accurate to my knowledge

________ I am certifying that I will notify the office of any change in my income.

________ I understand will be expected to bring verification of gross monthly income to the clinic at my next visit, or within thirty (30) days from my last visit; whichever is sooner. After 90-days, an incomplete application is defaulted to non-eligible status and all charges will be adjusted to full-pay.

______________________________	______________________________	______________
Full Name (Print)	Signature	Date