Open Cities Health Center
Community Health with a Heart

SLIDING FEE APPLICATION

Open Cities Health Center is committed to ensuring you and your family are able to receive the care that you need regardless of your financial status.

This is why we offer a discounted fee for patients and their families who are below 200% of the federal poverty guidelines. This is called a "sliding fee scale"; eligibility is based on family size and income.

Family/Household includes you, your spouse and your children under the age of 18.

Our Sliding Fee Scale applies to the following services: *Medical, Dental, Behavioral Health, Eye, and Chiropractic Services.*

Federal poverty levels change every year, it is your responsibility to apply on a yearly basis depending on your need or if your situation changes.

HOW TO APPLY FOR A SLIDING FEE DISCOUNT

Please complete the sliding fee scale form and provide the required proof of income and information about the individuals in your household.

Copies of the following items may be accepted as documentation of household income:

1. 4 weekly pay stubs or 2 bi-weekly pay stub / semi-monthly
2. Letter from employer stating number of hours, hourly wage and how often paid.
3. Social security, disability or pension benefit statements
4. Documentation of other governmental assistance
5. For self-employed individuals - a copy of their most recent Federal Income Tax Form 1040, Schedule C

If you have any questions please feel free to ask to speak to an OCHC Billing Staff.

Revised Date: 3/22/2016

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For Internal Use Only:

Please help us determine if you are eligible for discounted fees for services not covered by insurance. This information will be kept on file in our center in strict confidence. You will be required to provide proof of income and information about your household, your annual income will be used to calculate the level of your payment. This application will be valid for 12 months. This Eligibility form will be used to determine discounts for all OCHC services.

Medical Record # _____

PATIENT INFORMATION

Last Name:	**First Name:**	
Address:	**City, State**	**Zip Code**
Date of Birth:	**Social Security #**	**Gender:** ☐F ☐M

ADDITIONAL INFORMATION OF ALL INDIVIDUALS LIVING IN THE HOUSEHOLD
Please provide Names, DOB and SSN (*if one has been issued*) for all individuals living in the household:

Name	Relationship	Date of Birth	SSN	Patient at OCHC?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

INCOME INFORMATION

Number of people living in your home (Family size):

Wages/Salary income before deductions(gross):

OFFICE USE ONLY

You:	Your Spouse:	Total Family Income from Wages and other sources:
$ _____	$ _____	$ _____
Weekly☐ Biweekly☐ Monthly☐	Weekly☐ Biweekly☐ Monthly☐	Weekly☐ Biweekly☐ Monthly☐

Do you receive any income from any of the following sources? ☐Yes ☐No **If Yes, how much?**_____

Sources	You	Your Spouse	Your Children	Other person
Social Security				
Public Assistance				
Retirement Pension				
Rental Income				
Interest Income				
Child Support, Alimony				
Other (Specify)				

I do hereby affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws. I further agree to inform Open Cities Health Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Open Cities Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Signature:	Date: