Revised: 12/19/2017

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 ask to speak with the Open Cities Health Center Billing Staff.

Revised: 12/19/2017

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.

Medical Record #:____________________

PATIENT INFORMATION

Last Name:					**First Name:**			
Address:			**City, State:**			**Zip Code:**		
Date of Birth:			**Social Security #:**			**Gender:** ☐ **F** ☐ **M**		
Marital status:	**Married**		**Widow(er)**		**Single**		**Divorced**	

ADDITIONAL INFORMATION ON ALL INDIVIDUALS LIVING IN THE HOUSEHOLD

Give Names, DOB, and SSN of all individuals living in the household:

Name	Relationship	Date of Birth	Social Security #	OCHC Patient?			
				Yes		No	
				Yes		No	
				Yes		No	
				Yes		No	
				Yes		No	
				Yes		No	

INCOME INFORMATON

Number of people living in your home:				
Wage or Salary before deductions (Gross)				
Sources	**You**	**Your Spouse**	**Your Children**	**Other Person**
Social Security				
Public Assistance				
Retirement Pension				
Food Stamps				
Rental Income				
Interest Income				
Child Support, Alimony				
Other (Specify)				

I hereby affirm that to the best of my knowledge that the information provided on this application is true and correct. I understand that any misleading or falsified information and/or omissions may disqualify me for consideration for the program. I further agree to inform Open Cities Health Center if there are any significant changes in my income. If I accept the sliding fee program offered under this application, I will comply will all rules and regulations of Open Cities Health Center. I hereby acknowledge that I have read and understand the information setout above.

Signature: *Date:*