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.

We offer a nominal fee scale 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, or anybody else in your household that you support.

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 information form and provide the required documentation and information:

1. Information about the individuals in your household
2. ONE of the following proof of income documents :
   - Pay Stubs: 4 stubs if paid weekly –or– 2 stubs if paid bi-weekly (every 2 weeks)/semi-monthly (2 times a month)
   - Letter (with company letter head) from employer stating hourly wage, number of hours and how often paid.
   - Social security, disability or pension benefit statement letter
   - Documentation of other governmental assistance (see list under income information)
   - Most current W-2 or Federal Income Tax Form 1040, Schedule C
3. If no income :
   - Complete the pre written letter, sign and date it.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK TO SPEAK WITH THE OPEN CITIES HEALTH CENTER BILLING STAFF

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MEDICAL RECORD # _____

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 Your annual gross income will be used to calculate the level of your payment. This application will be valid for 12 months.

PATIENT INFORMATION

Last Name:			First Name:		
Date of Birth:	Gender: ☐ F ☐ M				
Phone Number:					
Address:					
Marital Status:	Single ☐	Married ☐	Divorced ☐	Separated ☐	Widow(er) ☐

ADDITIONAL INFORMATION ON ALL INDIVIDUALS LIVING IN THE HOUSEHOLD

Name (first, last)	Date of Birth	Relationship	OCHC Patient?
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N

INCOME INFORMATION

Number of people living in your home:

Sources of Income	You	Your Spouse	Your Children	Other Person
Wage/Salary (Gross)				
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 with all rules and regulation of Open Cities Health Center. I hereby acknowledge that I have read and understand the information setout above.

Signature: _____ Date: _____

REVISED: 9/5/2019