Health Care for the Homeless
Discounted Sliding Fee Schedule Application

Patient Name: ______________________________________ **Date of Birth:** ______________________

The policy of Health Care for the Homeless is to provide essential medical and dental services regardless of the patient's ability to pay for the healthcare services provided. Discounts are offered based upon family's size and income. Please provide the following information below and return this form to the front desk staff to determine if you or members of your family are eligible for a discount.

The discount will apply to healthcare services received at this clinic at the time of service, but will not cover those services which are purchased from outside our facility. For example, laboratory testing not offered at our clinic, certain medications, and x-ray interpretation by a consulting radiologist, etc.

Discounts are applied for a 6-month period. In the hopes that your financial situation improves, we ask that you notify the clinic as soon as possible to update your information. This form must be updated every 6 months in order to continue to receive the discount. If you have questions, please speak with a front desk staff.

Annual Household Income: Are you the head of Household: Yes ☐ No ☐ Number of persons living in your household: __________

Household Member	Household Income (complete one column)		
	Annual	**Monthly**	**Bi-Weekly**
Self			
Spouse			
Dependent Children Under age 18			
Total			

Note: List and include all sources of income, for example: gross wages, salary, tips, business or self-employment, unemployment or worker's compensation, social security, disability, public assistance, military or veteran's payments, pension or retirement, survivor's benefit, annuities, alimony, child support, and other miscellaneous sources of income.

Please list your spouse and dependents under the age of 18 below.

Dependent's Name	Date of Birth	Gender/Sex	Social Security Number
Spouse			
Dependent			
Dependent			
Dependent			
Dependent			

NOTE: Copies of tax returns, pay stubs, or other information verifying your income may be required before a discount is approved.

I certify that my family size and income shown above is correct.

____ ______________________________________

Patient's Signature Today's Date

Office Use Only

REMEMBER: Verify the patient's address, DOB, social security number, as well as their employment status listed on the patient registration form and/or in Success EHS in the patient's account.

Approved Discount Level: (please circle) A - B – C - D - E – F

ID Provided: Yes ☐ No ☐ ***Insurance Card Provided:*** Yes ☐ No ☐ ***Income Verified***: Yes ☐ No ☐

Co-Pay Due: $ __________Amount Paid $ _________ Placed on a Payment Plan: Yes ☐ No ☐

____ ______________________________________

HCH Staff Member's Signature Approval Date

Revised 04/22/2016