



Sliding Fee Scale Application

Clinic Site: _____

Because we are a Community Health Center, we have the opportunity to offer a discount on your services based on your annual income. If you feel this may be a benefit to you and your family, you will need to complete the Sliding Fee Scale program application and provide verification of income.

Head of Household Information:

Name: (First, middle initial, Last):		Social Security Number:	Date of birth:	County:
Address		City/State/Zip:	Home Phone:	Work Phone:
# of people being <u>supported</u> in the home:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			

If claiming zero income: Eligibility is only valid for one month.

Income Information: Please complete for all adult household members who are employed: **PROOF OF INCOME (INCOME TAX RETURN AND/OR LAST THREE PAYSTUBS) MUST BE PROVIDED TO KPCHC.** Otherwise, services will be rendered at customary price.

Employed Person/Patient	Company Name	Income (Before Taxes)	Paid how often? (Check One)
		\$	<input type="checkbox"/> Weekly <input type="checkbox"/> 2 times per month <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks
		\$	<input type="checkbox"/> Weekly <input type="checkbox"/> 2 times per month <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks
Other sources of income:	Alimony \$	TANF \$	Pension/Retirement \$
Child Support \$	Disability \$	S.S.I. \$	Social Security \$
Unemployment \$	Other \$	Other \$	Other \$

Household Information: List ALL individuals in household, including the head of household.

Name	Date of Birth	Relationship	Age	Income	Employed
1.					Yes/No
2.					Yes/No
3.					Yes/No
4.					Yes/No
5.					Yes/No
6.					Yes/No

Medical Application:

Dental Application:

Please make sure that you include your proof of income with this application

By signing below, I agree that the KPCHC staff may contact each employer listed and or other agencies to confirm my income. I will provide KPCHC with proof of income for the purpose of calculating my discount. I will be asked to reapply for the program on an annual basis. I agree to inform KPCHC if there are changes to my income, household size or insurance coverage. I understand that certain services and/or items cannot be discounted. I agree to pay my copay at the time of services. I hereby certify that the information I provide is correct.

Applicant Signature: _____ Date: _____

Guardian or Power of Attorney Signature: _____ Date: _____

Account #	
Effect Date	
Total Income	
Slide Scale:	