

Sliding Fee Scale Application
United Community Health Center

**APPLICATION WILL NOT BE ACCEPTED WITHOUT PROPER
COMPLETION AND PROOF OF INCOME
PLEASE BE SURE TO ANSWER ALL QUESTIONS**

Guarantor Full Name _____	MR # _____
Previous Name(s) _____	Date of Birth _____
Address _____	Apt/Lot # _____ Phone # _____
City _____	State _____ Zip Code _____

Please list all household members, including you, below:

Have you or any of your household members applied for Medicaid (Title XIX) yes ___ No ___
When/Who _____

MR#	First & Last Name	Date of Birth	Social Security #	Income Source	Relationship

Please indicate which of the following income sources your household receives, who receives it and how often it is received:

		Who		How Often				Who		How Often		
Yes	No	Employment			Yes	No	VA Benefits					
Yes	No	Child Support			Yes	No	Rental Property					
Yes	No	Unemployment			Yes	No	SSI/SSD					
Yes	No	FIP/Welfare			Yes	No	Worker's Comp					
Yes	No	Social Security			Yes	No	Self-employment					
Yes	No	Alimony			Yes	No	Cash Wages					
Yes	No	Pension			Other							

You are required to provide proof of above listed income in order to complete your application. The following are acceptable forms of income:

- Current Federal Income Tax (1040-1040 EZ Form)
- Current bank statement showing direct (SS, SSI, SSD, Fip, Child support)
- Pension payments, Veteran's benefits
- Paystubs for recent month
- Court order for alimony or child support or printout for child support payments
- Employer statement for cash wages (must include employer name, address and phone number)
- An award letter
- Printout from office issuing payments (SS, SSI, SSD, unemployment, VA, etc)
- Letter from caregiver

I declare that my household's financial status is as listed above. I realize that United Community Health Center is utilizing federal tax dollars to assist me in receiving health care. I understand that giving false information regarding my household income is considered fraud against the United States government.	
Applicant Signature _____	Date _____

Application Introduced By: _____ Date: _____ Due Date: _____

Patient's date(s) of service: _____ Amount Collected on DOS _____

Date SFS application received: _____ By: _____

Approved/Denied by: _____ Date: _____

Date SFS was entered into Computer: _____ By: _____

Calculated Income Total: \$ _____ Frequency _____

Expiration Date of SFS _____ Approved By _____

Comments _____

Sliding Fee Scale level assigned A B C D E

Patient Notify by: _____ Date: _____