Sliding Fee Application **HOH ID: ___________**

At Community Health Service Inc. (CHSI), patients are never turned away due to an inability to pay. CHSI offers a discount on your services based on your annual income and household size. Please complete the application below and provide documentation to verify your income. Your application will not be processed until income verification is received. However, CHSI will retroactively discount charges if an application is submitted within 30 days of the date of service.

Head of Household (Guarantor) Information:

<table>
<tr><td colspan="2">Name: (First, MI, Last)</td><td>Date of Birth (DOB):</td><td>SSN:</td></tr>
<tr><td>Mailing Address:</td><td></td><td rowspan="2">Primary Phone #:
☐ Cell ☐ Home ☐ Other</td><td rowspan="2">Secondary Phone #:
☐ Cell ☐ Home ☐ Other</td></tr>
<tr><td>City/State/ZIP</td><td></td></tr>
<tr><td colspan="2">Emergency Contact Name:</td><td>Phone Number:</td><td>Relationship to You:</td></tr>
<tr><td colspan="3">Email Address : ☐ Decline Patient Portal ☐ Sign-up for Patient Portal ☐ No E-mail Address</td><td>Insurance ☐ Yes ☐ No</td></tr>
</table>

Household Information: List all individuals you support.

Name (First, MI, Last)	DOB	Relationship to Guarantor	Insurance	SSN:
1.			**YES / NO**	
2.			**YES / NO**	
3.			**YES / NO**	
4.			**YES / NO**	
5.			**YES / NO**	

Income Information: Please include income of all household members who are employed.

<table>
<tr><td>1040 Tax Form
$</td><td>W2
$</td><td>Disability
$</td><td rowspan="2">Paystubs $
(Mark how often paid)
❑ Weekly ❑ Monthly
❑ Bi-Weekly ❑ Seasonal</td></tr>
<tr><td>Unemployment
$</td><td>TANF
$</td><td>Alimony
$</td></tr>
<tr><td>Child Support
$</td><td>Social Security
$</td><td>Pension/Retirement
$</td><td rowspan="2">Paystubs $
(Mark how often paid)
❑ Weekly ❑ Monthly
❑ Bi-Weekly ❑ Seasonal</td></tr>
<tr><td>Self-Attest
$</td><td>Other
$</td><td>Other
$</td></tr>
</table>

☐ **Not Federal Sliding Fee Qualified** ☐ **Refuse to Provide Income** **Total annual income: $ ____________**

Total # of people you support, including yourself: ________________ Calculated Sliding Fee: _________%

By signing below, I agree that CHSI staff may contact each employer and/or other agencies to confirm my income. I will be asked to reapply for the program on an annual basis. I agree to inform CHSI if there are changes to my income, family size, or insurance coverage. I understand that certain services and/or items may not be discounted. I agree to pay my nominal fee at the time of each visit whenever possible. I hereby certify that the information I have provided is correct.

Applicant Signature: _______________________________________ Date: ______________________

 Verified by (Staff Initials): __________

Part 2 of Sliding Fee Application

Household Information: List all individuals you support.

Name (First, MI, Last)	DOB	Relationship to Guarantor	Insurance	SSN:
6.			YES / NO	
7.			YES / NO	
8.			YES / NO	
9.			YES / NO	
10.			YES / NO	
11.			YES / NO	
12.			YES / NO	
13.			YES / NO	
14.			YES / NO	
15.			YES / NO	
16.			YES / NO	
17.			YES / NO	
18.			YES / NO	
19.			YES / NO	
20.			YES / NO	

Applicant Signature: ____ **Date:** ________________________