# ROCKING HORSE COMMUNITY HEALTH CENTER

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## Sliding Fee Discount Application

The sliding fee scale is a method for providing discounted charges to patients who qualify. This application, complete with income verification, will be in effect for 12 months from the date signed. You must reapply every 12 months. Circumstances that may affect your discount include divorce, death of spouse, loss of job or other income, leave of absence from work, etc. Additional verification may be required.
For consideration of eligibility, please provide the information requested below.

List the names and income of all persons who are living in your household, starting with yourself. Eligibility will be based on those you have been financially responsible for during the past 12 months. You may include an 18 year old only if the person is a full-time student and declared as a dependent on your tax return.

| Full Name | SSN (optional) | Date of Birth | Relationship | Employer | Income |
|---|---|---|---|---|---|
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Income includes **all income** for the **entire household** listed above. Please check appropriate box(es) of types of income and attach a copy of the item to be verified.

- ☐ Federal Income Tax Return
- ☐ Employee W2's
- ☐ Child Support/Alimony
- ☐ Interest or Rental Income
- ☐ Self employment Income
- ☐ Pay Report _____Weekly _____Bi-Weekly
- ☐ Pension/Retirement Benefits
- ☐ Social Security/Disability/Public Assistance
- ☐ Unemployment Comp/Strike Benefits
- ☐ I did not work or have any income

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes, (list below) ☐ No ☐

| Name of Insurance | Policy Number | Effective Date |
|---|---|---|
| | | |

**ACCEPT:** I understand that I may be eligible for discounted care, based on the documentation I have provided. I also understand that if I am eligible for a discount, I will be expected to pay the associated charge at the time of each office visit.

I have completed this application for discounted care and confirm that all information is correct to the best of my knowledge.

Applicant Signature Phone Number Date

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**DECLINE:** At this time, I choose to decline application of the Sliding Fee Discount Program. I understand that all out of pocket expenses incurred from services at RHCHC are my responsibility to pay, and ineligible for discount of the sliding fee schedule. I also understand that at anytime I may apply for consideration of eligibility for the Sliding Fee, for discounts on future charges.

Applicant Signature Date

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**For RHCHC Use Only:**

**Annual Gross Income** _____
Household Members _____

Eligible for Sliding Fee Discount? Yes No
Level_____ $_____

Application, completed with income verification and signature, expires one year from application date_____
Incomplete application expires three months from application date and granted one-day presumptive eligibility.

Patient Accounts Representative _____ Date _____