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Sliding Fee Discount Program

The following items are REQUIRED to process your application for the Sliding Fee Discount Program. Your application will NOT be processed without the requested information. Any information given to Community Health Northwest Florida or any of its locations will be kept confidential. If the information proves to be **FRAUDULENT** we reserve the right to cancel your Sliding Fee Scale status and bill you in full for all previous visits. Information needed (CHECKLIST):

1. _____ Complete Financial Assistance Form
2. _____ Copy of a current photo ID (ID can be scanned on site/extra copy not needed)
3. _____ Copy of most recent paycheck stub *OR* (if unemployed), a Letter of Support form
4. _____ Copies/proof of any of the following documents that apply: Supplemental Nutrition Assistance Program (SNAP) eligibility letter, SSI disability income, child support, unemployment, homeless ID card, etc.

Anyone in the household who is over age 18 and without a school transcript must apply individually.

BEFORE SIGNING, PLEASE READ THE FOLLOWING:

Community Health Northwest Florida or its satellite locations must be notified immediately if:

a. There is a change of income (increase or decrease) of any family member in the household listed on original application.
b. Any member of the household, if listed on original application, obtains insurance of any kind.
c. There is a change of mailing address or phone number.

You must pay your fee at the time of each visit. If you do not pay your fee or are not qualified during the current visit, you MUST pay the balance of your account and/or bring in the required documents within 7 business days. If payment or documentation is not received, Community Health Northwest Florida or its satellite locations reserves the right to TERMINATE your eligibility in the Sliding Fee Discount Program and pursue further collection efforts.

_____ _____
Applicant's Signature Date

_____ _____
Financial Counselor's Signature Date

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PATIENT REGISTRATION FORM

Patient Name: _____

Address: _____
Street City State Zip

Phone: (Home) _____ (Cell) _____ (Work) _____

DOB: _____ SS#: _____ Sex: ◯ Male ◯ Female

Marital Status: Single / Married / Separated / Divorced Spouse: _____ DOB: _____

Race: ◯ More than one race ◯ African American ◯ White/Caucasian ◯ Asian
◯ Native Hawaiian/Other Pacific Islander ◯ American Indian/Alaska Native

Are you Hispanic? (Please circle one) Yes No

Emergency Contact: _____ _____
Name Phone #

Does the patient have any type of medical insurance? (Please circle one) Yes No If yes, please circle which:

Medicaid Share of Cost Family Planning Medicare Disability Other

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I declare the information contained on this form to be true and correct to the best of my knowledge and consent to the verification of this information by Community Health Northwest Florida or its satellite locations. I also authorize Community Health Northwest Florida or its satellite locations to release any information to any insurance company, the Florida Division of Family Services, Center for Medicare and Medicaid Services or any of their respective agencies that I may have designated as providing insurance in order to secure payment for any treatment provided by Community Health Northwest Florida or its satellite locations.

_____ _____
Signature Date

Office Use Only

Monthly Income: _____ (x12 =) Annual Income: _____ # in household: _____
◯ no LOS ◯ w/LOS

Approved financial classification: ◯ $0 ◯ $5 ◯ $20 ◯ $35 ◯ $40 ◯ DNQ Financial Counselor initials: _____

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Certification of Low Income Status
Income Assessment Worksheet

Please list income for all dependent family members. This does not include guests, roommates or non-dependent family members. Definition of Income: Cash wages and benefits, regular payments from Social Security, Unemployment, AFDC or TANF, SSI, Alimony, pensions. Excluded are non-cash benefits such as SNAP, school lunch program benefits, and housing assistance.

Source	Amount	Weekly	Bi-Weekly	Monthly	Annually
Salaries and Wages (Self)	_____	◯	◯	◯	◯
Salaries and Wages (Spouse)	_____	◯	◯	◯	◯
Worker's Compensation	_____	◯	◯	◯	◯
Social Security (Self/Spouse)	_____	◯	◯	◯	◯
Social Security (Children)	_____	◯	◯	◯	◯
Child Support/Alimony	_____	◯	◯	◯	◯
Unemployment	_____	◯	◯	◯	◯
Military/Veterans Benefits	_____	◯	◯	◯	◯
Other Public Assistance	_____	◯	◯	◯	◯
Pension/Retirement	_____	◯	◯	◯	◯
Other	_____	◯	◯	◯	◯

Please list all *dependent* family members by NAME, DATE OF BIRTH, and SOCIAL SECURITY NUMBER. Please include yourself, your spouse, and your children.

Definition of a Family: A family is a group of 2 or more persons related by birth, marriage, or adoption who live together. This also includes college students who are supported by their parents or others related by birth, marriage or adoption, regardless of where the student lives.

Name	Date of Birth	Social Security Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Community Health Northwest Florida reserves the right to inspect your tax return and/or wage statements for previous periods upon request. Eligibility will be updated on an annual basis. If there are any changes in your income status prior to your annual update, you should notify Community Health Northwest Florida immediately.

I hereby certify that the income and family composition information supplied in the above table is true and correct to the best of my knowledge. I understand this document will be maintained for a period of one year and that falsification of information may result in termination of my eligibility in the medical assistance program (sliding fee schedule).

Signature_____ Date_____

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Letter of Support Provided to Community Health Northwest Florida

Patient Name:_____

I provide the following support, without any charge or exchange to the above person (estimate monthly amount):

_____Housing

_____Food

_____Expenses

I understand that by signing this letter of support for the above named patient does not obligate me to pay for medical services provided to the patient at Community Health Northwest Florida. The purpose of this letter of support is to assist the patient in qualifying for the sliding fee scale program so he/she can obtain medical assistance at Community Health Northwest Florida.

Community Health Northwest Florida is a federally qualified health center. I understand that it is a violation of law to provide false information in order to secure federally supported health benefits. I also agree to provide a copy of my driver's license and social security card in order to complete this letter of support for the above named person.

Signature: _____

Print Name: _____

Relationship to Patient: _____

Today's Date: _____