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northwest florida
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Sliding Fee Discount Application

It is the policy of Community Health Northwest Florida to provide services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. The discount will apply to all services received at any of our clinics, but not services or equipment that are provided by outside entities. Please complete the following information to determine if you or members of your family are eligible for a discount.

____
Name of Head of Household (Last, First, Middle)

____
Mailing Address (No P.O. Boxes)

____
City State Zip

____
Phone E-mail

Household Size: List all members living in the household. Household considered all persons living at the same address.

Name Date of Birth Relationship

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***** If approved for the Sliding Fee Discount Program, applicants will be eligible for discounts for a period of twelve months following the month of approval into the program. *****

Income Documentation		Pay Frequency			
Source	**($)**	**Weekly**	**Biweekly**	**Monthly**	**Annually**
Salaries / Wages (Self)					
Salaries / Wages (Spouse)					
Salaries / Wages (Other)					
Social Security Income (Self / Spouse)					
Social Security Income (Children)					
Child Support / Alimony					
Workman's Compensation					
Military / Veterans Benefits					
Unemployment Benefits					
Other Family Member(s) Income					

Note: Adequate information is required to determine eligibility for the sliding fee discount program. Applicants must provide one of the following: recent pay stub, prior year tax return, or a letter from employer. Patients who are unable to provide any of the above documents may be required to provide a signed self-declaration of income.

I certify that the family size and income information shown above is correct. By signing this form, you are authorizing Community Health Northwest Florida to confirm income as disclosed on the application. The provision of false information by an applicant may result in dismissal from the sliding fee discount program.

____ __________________________

Signature Date

____

Name (Print)

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Determination Statement

Patient Name: ____

Application Received Date: ____________________ By: _________________________________

Eligibility Determination: Approved Denied

If Approved, eligible for Discount Category: ____

If Denied, reason for Denial: ____

____

Verification Checklist	Yes	No
Identification Verification Source: Driver's License, State Issued ID, Passport / Visa, School Issued ID, or Other		
Income Verification Source: Recent Pay Statement, Prior Year Tax Return, Letter from Employer, or Other		

Comments/Notes:

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____ ____________________________

Financial Counselor Signature Date

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Self-Declaration Form

____
Name of Head of Household (Last , First, Middle)

____
Mailing Address (No P.O. Boxes)

____
City State Zip

____
Phone E-mail

I declare that my household income is _______________ per _______________.
($) (period)

I also certify that a total of _____________ people are living in my household.
(number)

The provision of false information by an applicant may result in dismissal from the sliding fee discount program.

I hereby certify that the information provided above is true and correct to the best of my knowledge. I understand this information will be used to determine eligibility for the sliding fee discount program.

____ ____________________
Signature Date

____
Name (Print)