

### 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.

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Patient Name (Last, First, Middle) Date of Birth

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Mailing Address (No P.O. Boxes)

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City State Zip

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Phone E-mail

**Household Size:** List all family members living in the household. Family is defined as a group of two (2) people or more related by birth, marriage, or adoption and residing together 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 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)					
Social Security Income (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)



### Determination Statement

Patient Name: \_\_\_\_\_

Application Received Date: \_\_\_\_\_ By: \_\_\_\_\_

Eligibility Determination:                      Approved                      Denied

If Approved, eligible for Discount Category: \_\_\_\_\_

If Denied, reason for Denial: \_\_\_\_\_

\_\_\_\_\_

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

Comments/Notes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Financial Counselor Signature

\_\_\_\_\_

Date



### Self-Declaration Form

\_\_\_\_\_  
Patient Name (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)