community health
northwest florida
HealthcareWithinReach.org

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.

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

Mailing Address (No P.O. Boxes)

City State Zip

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

***** 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. *****

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Determination Statement

Patient Name: _____

Application Received Date:_____ By: _____

Eligibility Determination (circle): Approved Denied

If application approved, eligible for Discount Category: _____

If application 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