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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Self-Declaration Form

_____

Name of Patient (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)