Date Received by CHNWF: _____

Staff Initials: _____

community health
northwest florida
HealthcareWithinReach.org

DUE BY:_____ **(Date)**

APPLICATION FOR SLIDING FEE

Patient Name:_____
(Last) (First) (Middle) (Acct #)

Guarantor Name:_____
(Last) (First) (Middle) (Acct #)

Guarantor Mailing Address: _____
(Street or Box #) (City) (State) (Zip) (County)

Guarantor Marital Status: _____Single _____Married _____Divorced _____Widowed

Guarantor Birth Date: _____ Age:_____ Sex: _____F _____M

Guarantor Social Security #_____ Phone: _____

Guarantor Employed? _____YES _____NO Occupation: _____

Employer's Name:_____ Phone:_____

Do you have any of the following? _____Insurance _____Medicare _____Medicaid

Would you like to explore your eligibility for Medicaid or insurance? _____YES _____NO

FAMILY UNIT

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.

(Notate beside names which type of coverage(s) apply)

Name	Type of Coverage	Relationship to Patient	Date of Birth	Sex

(Please list any additional members on a separate sheet of paper and provide it to front desk staff at your appointment)

INCOME (All Sources Must be Included)

	Hours Per Week	Per Hour Rate	Weekly Rate	Monthly Rate	Yearly Rate
Head of Household					
Spouse					
Other					
Other					

TOTAL FAMILY MEMBERS:_____TOTAL ANNUAL INCOME: $_____SLIDE FEE RANK: _____

By signing my name to this form, I am certifying the information given is true, accurate and complete to the best of my knowledge. I understand if I provide false information, I am liable for prosecution under State and/or Federal law. I give consent to CHNWF to verify the information on this application. I understand this application must be renewed in 12 months from application date.

_____
Patient/Guardian Signature

☐ **PATIENT DECLINED**

_____
Application Date

Slide Fee Application Requirements

An application for slide fee, or discounted fee for services, is offered to all patients and must be renewed at least annually. The discount is based on gross family income and family size in accordance with Federal Guidelines set forth in the Federal Register. The application must be completed, signed and returned with the following types of proper income verification in the **next ten (10) days.**

1. Prior year tax return;
2. IRS Form W-2 Wage & Tax Statement for the prior year;
3. Check stubs for two (2) recent pay periods from the employer(s) and rate of pay to insure consistency per pay period for each employed family member;
4. Most recent Social Security Administration benefits statement;
5. Letter from your employer verifying income

Patients who are unable to provide any of the above documents may be required to provide a signed self-declaration of income.

The slide fee application must be completed with proper proof of income or you will be charged full price for your visit.

Slide Fee Due at the time of the Appointment

Medical Services	Dental Services
Level A = $20.00	Level A = $40.00
Level B = $25.00	Level B = $45.00
Level C = $40.00	Level C = $55.00
Level D = $55.00	Level D = $65.00
Level F = $120.00	Level F = $120.00

Depending on your approved eligibility for slide fee discounts, the level's nominal fee is expected before each office visit.

_____

Patients Signature and Date acknowledging Patient understands the Slide Fee Program Requirements.