Date of Application: _____
Temporary Sliding Fee: $_____
Health Insurance: Yes/No
Type of Insurance: _____
Date of Service_____

2/2020

ARE YOU ELIGIBLE FOR A DISCOUNT?

Island Health Care Community Health Center (IHC) provides discounted fees for patients who are income eligible. We call these "sliding fees." EVEN IF YOU HAVE HEALTH INSURANCE, YOU MAY QUALIFY!!

Head of Household Name_____
Patient:(First, Middle, Last) _____ Date of Birth_____
Address:_____City/State/Zip_____
Best telephone number to reach you_____ # family members in household: _____
Annual Family Income$_____

Household Information: List all family members in household including yourself in line 1.

Name	Date of Birth	Relationship	Employed	Annual Income
1._____	_____	_____	Yes/No	$_____
2._____	_____	_____	Yes/No	$_____
3._____	_____	_____	Yes/no	$_____
4._____	_____	_____	Yes/No	$_____
5._____	_____	_____	Yes/No	$_____

ZERO INCOME? IF SO, ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED TO QUALIFY.
Name of last employer:_____ Date of last employment_____
Income earned so far this year_____*Please explain how your basic needs have been met:(How do you pay for)Food:_____ Utilities:_____Shelter:_____ Non-Food Items:_____*
I _____,certify that I have had no source of income since_____
Do you expect to become employed_____ , if so when _____ expected weekly income_____

You are required to verify* and report your income when you become employed. Failure to provide this information will result in the termination of your sliding fee.

Please sign the following simple attestation: I certify that the information provided is accurate to the best of my knowledge, and that if I pay a discounted fee for today's visit, **I will provide the required documentation to IHC within 14 days or by the time of my next visit, whichever is sooner**. If upon review IHC determines that I am NOT eligible for a discount or I fail to submit the required follow-up documentation, I agree that I am responsible for the non-discounted fee for today's visit. I understand that I will be asked to update this information on annual basis. I understand I am fully responsible for my bill if I do not comply with the above requirements.

_____ _____ _____

Full Name (Print) Signature Today's Date

***One of the following forms of proof of income MUST be provided within 14 days of this application.**

a. Most recent Income Tax Return with attached W2's and/or 1099"s
b. Pay check stubs: Two or more recent consecutive pay stubs.
c. Employer Letter: For those not receiving an actual pay check, a letter from employer detailing current gross income and frequency of pay periods may be accepted. Contact information must be provided so that information can be verified.