Sliding Fee Application

Patient Information			**Today's Date:** / /	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address: (if different from above)		City:	State:	Zip:
Home Phone #: ( ) -		Cell Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No If yes, please provide insurance card to receptionist	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size			
Name	**Date of Birth**	**Social Security #**	**Relationship**
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. This form must be completed yearly in order to renew your eligibility. Please bring yearly income tax return, copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive as proof of family income. Only the family size and annual income will be used to determine your eligibility and calculate your discount.

Household Income			
Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Other Income					
Total					

I certify that the information on this application is true and accurate. I understand that it is my responsibility to complete the application and provide the required proof of income documentation, identification, and proof of residency, in order to apply for discounted services. I understand that as a **New Patient,** I must provide the required documentation prior to, or at the time of the office visit, or be responsible for the full charges. In addition, I understand that as an established patient re-applying for discounted services, I will have no more than 30 days from the date of service to provide the required income, identification, and residency documentation, or be responsible for full charges.

I agree to inform the Family Health Center of Southern Oklahoma if my household size or financial situation changes significantly. I also understand that falsifying information or documentation on the application will result in my application being denied and any applicable discounts received under false pretenses will be revoked and I will be responsible for all charges. I understand that this application, and any discount that I may qualify for, will apply only to the patient listed on this application. Any/all additional patients would need to apply separately.

I agree to help the Family Health Center of Southern Oklahoma check any information on this application and let them get needed information from employers, government agencies, medical providers, and other sources.

The discount will apply to all services received at the clinic, but not those services or equipment that are purchased from the outside, including any reference laboratory testing, drugs, an x-ray interpretation by a consulting radiologist, and other such services.

Name (Print):________________________________

Name (Signature): ________________________________

Date:__________________

Office Use Only	
Patient Name	
Approved Discount	
Approved By	
Effective Date	
Patient Number	
Identification/Address/Proof of Residency: Driver's License, utility bill, employment ID, or other	□ Yes □No
Income: Prior year tax return, two most recent pay stubs, or other	□Yes □No
Insurance: Insurance Cards	□Yes □No