FHCSO

APPLICATION FOR SLIDING FEE SCALE
FINANCIAL ASSISTANCE

Name:_____ Date:_____
(First) (Middle Initial) (Last)

Social Security Number_____ Date of Birth___ ___ ____
(or ITIN Number) (MM) (DD) (YY)

Marital Status: Single ___Married ____Divorced ___ Widow_____

Spouse Name_____

APPLICANT AFFIDAVIT

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 my 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 10 business 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 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 am aware that the FHCSO is regulated by policies and regulations established by the federal government, and it is considered unlawful to misrepresent or falsely claim inaccurate information on this application.

I agree to: help the FHCSO check any information on this application, and let them get needed information from employers, government agencies, medical providers, and other sources.

_____ _____
PRINT NAME OF APPLICANT SIGNATURE OF APPLICANT

_____ _____
FHCSO Staff DATE

HOUSEHOLD INFORMATION

Please list everyone living in your home (including yourself), that meet the following criteria: 1) All persons claimed on your federal income tax return. 2) Non-related adults that contribute to the household income (food/rent/utilities).

PLEASE PRINT

Name (First and last)	Age	Date of Birth	Social Security Number/ ITIN	Source of income (wage/social security/etc)	How often are you paid?(Every week; Every other week)	Relationship to Applicant
1.						
2.						
3.						
4.						
5.						

Please include income documentation for each ADULT listed above.

INSURANCE

Do you, or the patient you represent, have medical/dental insurance? ____Yes ____No

If YES, **please provide a copy of the front and back of your insurance card(s) to the front desk.**

SLIDING FEE SCALE REGISTRATION REQUIREMENTS

Proof of identification:

Please bring one of the following identifications (if it is not currently on file).

- Social security card
- Valid driver's license or current personal state ID
- Birth certificate
- ITIN card (individual tax identification number) or ITIN assignment document
- Passport

Proof of residency:

Please bring one of the following forms to prove residency (if it is not currently on file).

- Recent utility bill
- Recent rent or mortgage receipt
- Recent pay stub that includes listed home address
- Benefit award letter sent to listed home address

Note: residency is not required to receive medical treatment.

Please bring income documentation for each person on the Sliding Fee Scale application that contributes toward food, rent or utilities. **Current documentation must be provided when renewing your Sliding Fee Program status.**

SLIDING FEE PROGRAM-PROOF OF INCOME

As a Federally Qualified Health Center (FQHC), The Family Health Center of Southern Oklahoma (FHCSO) is able to provide sliding fee discounts for self-pay and underinsured patients who meet income eligibility requirements. Self pay and underinsured patients may qualify for the discount program based on family size and proper documentation of **all household income.**

The following list is considered acceptable documentation to prove household income:

A) A previous year's Federal Tax Return (Form 1040, 1040A, 1040EZ) for each working person in the household. (Need IRS transcript if self-filed by hand)
B) Two full months (most-recent) pay check stubs for each working person in household.
C) Employee Verification forms, signed by employer listing: date of hire, rate of pay, and hours worked, etc. The form should be notarized; at the least, personal verification with the employer will need to take place.
    a. If the employee has worked less than two months, we will accept the pay stubs or notarized documentation that is available. In this situation, FHCSO will **EXPIRE the sliding fee status after the current visit**. At the next visit the patient will be responsible for providing the previous two months pay check stubs to establish eligibility.
    b. When all required documentation is provided, Sliding Fee eligibility will exist for 1 year, or until there is a substantial change in household income, or a change in household size.
D) Award letter from the Social Security Administration OR bank statement indicating direct deposit from the Social Security Administration of the U.S. Treasury Check.
E) Notification letter or check stubs from the Unemployment Office stating benefit amount. These forms must include the patient's name and/or Social Security number.
F) Notification letter of pension, retirement or disability benefits received OR a current bank statement indicating direct deposits for pension, retirement or disability benefits.
G) Child Support Award court order
H) Income Verification from the Oklahoma Department of Human Services
    a. Award Letter ("HA" Form) showing Food Stamp allotment (for any household member receiving food stamps).