



## SLIDING FEE DISCOUNT APPLICATION

It is the policy of FHP Health Center to provide essential services to all patients, regardless of their ability to pay. To make healthcare more accessible, we offer discounts based on family size and annual income. To determine your eligibility for a discount, please complete the form below and return it to the front desk. *The discount applies only to clinic visits and does not cover external services such as laboratory tests, medications, x-ray interpretation by a consulting radiologist, medical equipment/supplies, vaccines or other similar services.* This form must be completed annually or whenever there is a change in your financial situation. A completed application, along with income verification, must be submitted and approved by the Billing Office Manager or their designee before any discount is applied.

### I. APPLICANT INFORMATION

Applicant's Name: (Last, First, Middle)		Date of Birth:
Email:	Home Phone:	Mobile Phone:
Mailing Address:		
City:	State:	Zip Code:
Physical Address:		
City:	State:	Zip Code:

### II. HOUSEHOLD SIZE INFORMATION Please list all individuals in the household, including those under the age of 18.

Name: (Last, First, Middle)	Relationship: <b>SELF</b>	Date of Birth:

If more space is needed, please attach a separate sheet with additional dependents.

### III. HOUSEHOLD EARNINGS INFORMATION Please indicate all members living in your household who contribute financially, including the applicant:

Name: (Last, First, Middle)	Source of Income/Employer:	Monthly Gross Income:
		\$
		\$
		\$
		\$
<b>TOTAL MONTHLY INCOME</b>		\$
<b>TOTAL ANNUAL INCOME</b>		\$

Please attach a separate sheet with additional sources of income if needed.

**Acceptable Proof of Income:** Please provide a copy of one of the following for income verification for all household members who are 18 years or older that contribute to the household income: Prior year W-2, 1099 form, Two most recent pay stubs, Letter from employer, Form 4506-T (if W-2 not filed), Self-employed individuals: Submit detailed records of the most recent three months of income and expenses for the business, Gross receipt tax.

**IV. REQUIRED INFORMATION**

Please check the documentation you are submitting with this application. FHP Health Center cannot provide a discounted fee without the required documents.

 **Completed Application Form** **Proof of Income** (e.g., pay stubs, W-2, employer letter) **Valid Government-Issued Photo ID****V. CERTIFICATION**

To the best of my knowledge, the information provided above is the accurate and complete for all members of my household. I understand that if any information I have submitted is determined to be false, I will no longer be eligible for the sliding fee discount. Should this occur, I will be held responsible for any out-of-pocket expenses incurred.

Applicant's Name:	Name of Representative:
Signature:	Signature:
Date:	Date:

**DO NOT WRITE BELOW - FOR OFFICIAL USE ONLY****VERIFICATION CHECKLIST**

Received by:	Date:
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 **Completed Application Form** **Proof of Income** (e.g., pay stubs, W-2, employer letter) **Valid Government-Issued Photo ID** **APPROVED**

- 10% Discount
- 20% Discount
- 30% Discount
- 40% Discount
- 50% Discount
- \$\_\_\_\_\_ Nominal

 **DENIED**

- Incomplete application
- Lack of Household Information
- Lack of Supporting Documents
- Income exceeds 200% of federal income poverty guideline

Reviewed By:	Date:
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Remarks:

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Applicant notified on date:

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