ROCKING HORSE COMMUNITY HEALTH CENTER

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Sliding Fee Discount Application

The sliding fee scale is a method for providing discounted charges to patients who qualify. This application, complete with income verification, will be in effect for 12 months from the date signed. You must reapply every 12 months. Circumstances that may affect your discount include divorce, death of spouse, loss of job or other income, leave of absence from work, etc. Additional verification may be required.
For consideration of eligibility, please provide the information requested below.

List the names and income of all persons who are living in your household, starting with yourself. Eligibility will be based on those you have been financially responsible for during the past 12 months. You may include an 18 year old only if the person is a full-time student and declared as a dependent on your tax return.

Patient's address: _____ Phone # _____

Full Name	SSN (optional)	Date of Birth	Relationship	Employer	Income	Check if current patient.
			Self			☐
						☐
						☐
						☐
						☐
						☐
						☐

Income includes the most recent four weeks of the following documents for the **entire household** listed above. Please check appropriate box(es) of types of income and attach a copy of the item to be verified.

- ☐ Payroll: How often are you paid? ☐ Weekly ☐ Every other week ☐ Once per month
- ☐ Employee W2's
- ☐ Child Support/Alimony
- ☐ Interest or Rental Income
- ☐ Self employment Income
- ☐ Pension/Retirement Benefits
- ☐ Social Security/Disability/Public Assistance
- ☐ Unemployment Comp/Strike Benefits
- ☐ I did not work or have any income

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes, (list below) ☐ No ☐

Name of Insurance	Policy Number	Effective Date

ACCEPT: I understand that I may be eligible for discounted care, based on the documentation I have provided. I also understand that if I am eligible for a discount, I will be expected to pay the associated charge at the time of each office visit.

I have completed this application for discounted care and confirm that all information is correct to the best of my knowledge.

Applicant Signature Phone Number Date

DECLINE: At this time, I choose to decline application of the Sliding Fee Discount Program. I understand that all out of pocket expenses incurred from services at RHCHC are my responsibility to pay, and ineligible for discount of the sliding fee schedule. I also understand that at anytime I may apply for consideration of eligibility for the Sliding Fee, for discounts on future charges.

Sign to Decline: Date

For RHCHC Use Only:

Annual Gross Income _____
Household Members _____

Eligible for Sliding Fee Discount? Yes ☐ No ☐

Level_____ Nominal Fee$_____

SF Eff Date_____ SF Exp Date_____

Application, completed with income verification and signature, expires one year from application date.
Incomplete application expires three months from application date and granted one-day presumptive eligibility.

Income Calculation:

Pay Frequency	#1 +	#2 +	#3 =	Total X Multiplier	Total	X12 = Gross Annual
Gross Weekly Avg:	_____ +	_____ +	_____ =	_____ X 4.3 =	_____	X12 = _____
Gross Bi-Weekly Avg:	_____ +	_____ +	_____ =	_____ X 2.15=	_____	X12 = _____
Gross Monthly Avg:	_____ +	_____ +	_____ =	_____ X 0 =	_____	X12 = _____

Total Household Gross Annual Income = _____

Patient Accounts Representative _____ Date _____