NORTHEASTERN RURAL HEALTH CLINICS

SLIDING FEE SCALE APPLICATION

APPLICANT INFORMATION

Applicant Name: _____
last first middle

Mailing Address: _____
street city zip

Telephone: _____ Date of Birth: _____

Social Security Number: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated

RESPONSIBLE PARTY

Guarantor Name: _____
last first middle

Relationship to Applicant: _____

Social Security Number: _____

Employer: Phone Number:

INCOME INFORMATION

If no income is reported, a note explaining your living situation and how your monthly expenses are being met must be written on the back of this form

Employment Wages (A)

Monthly $ _____ Weekly $ _____

Every Two Weeks $ _____ Twice a month $ _____

Self Employment Income Monthly $ _____

☐ > Greater than 200% of FPL
(Not Qualified for Discount Program)

Other Sources of Income	**Monthly Amount**
Child support/Alamony	$
Unemployment	$
Disability/Workers Comp	$
Interest/Dividends	$
Social Security/SSI (includng Veteran's and Survivor)	$
Pensions	$
Rental Income	$
Public Assistance	$
Other (list source)	$
Total (B)	$

Household Members	**Date of Birth**
*Includes all household income	
1	
2	
3	
4	
5	
6	
7	
8	
Total Members	

INSURANCE INFORMATION

Do you have any type of medical insurance coverage? ☐ Yes ☐ No

If yes, please complete:

Insurance Name: _____ Subscriber Name: _____

Group Number: _____ Effective Date: _____

INCOME VERIFICATION

********** **Please attach copies of income verification**. **********

Please remember that you will remain as a self pay patient until this information is received.

Unless income verification is provided, you will be held liable for the full amount of charges.

The sliding fee scale discount only applies to charges incurred within AAPHC clinics and not to any outside services.

*I understand that giving false information will result in the denial of discount benefits, that I will be responsible for the full fee and no longer be eligible for the Fee Discount Program.

*Applying for a discount does not guarantee that you will receive a discount. If you fail to notify us of any changes in income or family size the clinic may immediately reverse any discounts.

*By signing below you are authorizing the release of information to NRHC to verify all stated information on Fee Discount Program at our Discretion.

I verify that this information presented is true and accurate to the best of my knowledge and hereby apply for the sliding fee scale discounts as applicable.

Signature: _____ Date: _____

Office Use Only:

Chart Number: _____ Sliding Scale Code: _____

Approved by: _____ Date: _____

Weekly Pay X 4.33:	Every 2 Weeks Pay X 2.167:	Twice a month pay X 2:
Family Size:	Wages (A)	
		Category (B,C or D) Fee
Other Income (B)		
Total Household Income:		
Reviewed By	Renewal Date	

Revised 06/10/2022 Effective Date of SFS Discount: _____