Application for Sliding Fee

Shortgrass Community Health Center offers patients a discount on their medical bills if they qualify for our sliding fee scale. The discount is based on the **GROSS** income of **ALL** members of the household and the number of members in the family. If you want to apply for this discount we need income verification. **Proof of income is required.**

(Examples: most recent pay stub, prior year's W-2 forms, tax returns, bank statement showing deposits, letter of income from employer, attestation letter from someone not a household member, self-attestation letter.)

Please list ALL family members: (*Frequency = Weekly, Biweekly, Bimonthly, Monthly, or Annual*)

Name	Date of Birth	Income	Frequency

** **Patients applying for the sliding fee program are obligated to contact SCHC if their income or household status changes, or if they become eligible for insurance. Patients must update information on an annual basis to remain on the sliding fee program.**

AFFIDAVIT

By signing below, I attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the family members listed are all solely dependent on that income, or thatthe explanation provided to verily my income level is truthful. I understand that I have 30 days to provide proof on income or I will be responsible for promptly paying the full charge of all visits.

APPLICANT SIGNATURE _____ ***DATE*** _____

Sliding Scale Discount (FOR OFFICE USE ONLY)			
Total household WEEKLY income	_____	Total # of household members	_____
Total household BIWEEKLY income	_____	**Staff calculations**	
Total household BIMONTHLY income	_____		
Total household MONTHLY income	_____		
Total household ANNUAL income	_____		
VALID from: _____ (month/day/year)	TO _____ (month/day/year)	_____ (Authorized Office Staff Signature)	