Shortgrass
COMMUNITY HEALTH CENTER, INC.

Application for Sliding Fee Discount Program

Shortgrass Community Health Center offers patients a discount on their medical bills if they qualify for our sliding fee discount. The discount is based on the **GROSS** income of **ALL** members of the household (according to SCHC policy) 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 for the most recent 8 weeks. (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*)

Household Member Name	Relationship to patient	Date of Birth	Income (Gross)	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. Eligibility is valid for up to 12 months unless the patient's financial circumstances change.**

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 that the explanation provided to verily my income level is truthful. I understand if I refuse to provide acceptable proof of income, SCHC will reassess my eligibility for the Sliding Fee Discount Program in accordance with written policies, potentially resulting in my being responsible for the full charge of services.

APPLICANT SIGNATURE _____ ***DATE*** _____

Sliding Scale Discount (FOR OFFICE USE ONLY)

Total household WEEKLY income_____ Total # household members_____

Total household BIWEEKLY income _____ **Staff calculations**

Total household BIMONTH income _____

Total household MONTHLY income _____

Total household ANNUAL income _____

VALID from: _____ TO _____ _____

(month/day/year) (month/day/year) (Authorized Office Staff Signature)

Income Category: ☐<=100% ☐101-150% ☐151-200% ☐over 200% Sliding fee calculator completed: ☐