SISKIYOU COMMUNITY HEALTH CENTER
Sliding Discount Program Application

At Siskiyou Community Health Center we offer a sliding discount program so you can receive quality care even when you may not have the ability to pay full fees. Our sliding discount program is based solely on family size and income in relation to the Federal Poverty Level. To be considered for this program you need to complete the following application and submit proof of income. If you do not supply adequate proof of income or you do not qualify based on the proof of income received, you will be responsible for the full charges. Once you have qualified for the program you will be eligible until March 31st. **A new application and proof of income is required each April 1st or your first visit after this date.**

PLEASE USE BLUE OR BLACK INK TO COMPLETE THIS APPLICATION.

1 APPLICANT INFORMATION

Name of Responsible Party _____DOB _____ Phone _____

Address _____ City _____ State _____ Zip _____

2 HOUSEHOLD MEMBERS

This includes self, spouse and dependents under 19 years old. Other adults in the household, even if related, are not included and will be considered separately.

NAME (First Last)	RELATIONSHIP	DATE OF BIRTH	GROSS MONTHLY INCOME
_____	SELF	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3 PROOF OF INCOME

Proof of Income is required for each adult listed above. Acceptable forms of proof include:

- **Pay Stubs:** A full months worth of Pay Stubs for the most current month (2 months, if paid monthly). Must include employer name, pay period and gross wage.
- **Letter of Determination for:** Social Security, Disability, Unemployment (must show gross weekly amount), Child support/alimony, Worker's Compensation
- **Self Employed applicants:** Copy of your Federal Tax return (1040) from last year with signature page (Do Not Submit W-2s or 1099s).

4 SIGNATURE

I understand that the information I provide will be used to determine my/our ability to pay. The information above is true to the best of my knowledge. I understand that if I lie to get a reduced fee, I am committing fraud.

Signature_____ **Date** _____

FOR OFFICE USE ONLY

PROVISIONAL SLIDE DETERMINATION

Date Provisional Slide Used _____ **SCHC Initials** _____

If the Provisional slide is being used for today's application, indicate the family size/income estimated from the application and the discount amount. If the Provisional slide was previously used, leave the below lines blank.

Income Determination from application _____ Family **Size from application** _____

Provisional Slide Discount **A** **B** **C** **D** **NONE**

ANNUAL INCOME CALCULATION

Proof Received:

____ Pay Stubs

____ Social Security Award Letter

____ Unemployment Documentation

____ Federal Tax Return

____ Child/Alimony Support

____ Unable to Provide Documentation Letter

____ Other _____

Additional Notes:

Provisional Income:

Income Based on Proof:

DOCUMENTATION RECEIVED/DETERMINATION

Family Size (#): _____ Documented Family Annual Income: $_____

Qualifies for Slide: Yes ___ No ___ If no, why? _____

Discount Category (circle): **A** **B** **C** **D**

_____ _____

Siskiyou Community Health Center Signature **Date**

1*-verify front page complete and signed 2-Add Prov Slide Note on all patients* ***3****-Enter/update payer & link to Enc*

5*-add income info* ***6****-date stamp all documents 7-Verify back page is complete*