

COMMUNITY HEALTH CENTERS, Inc.
SLIDING SCALE APPLICATION
Solicitud para el programa de la escala de descuentos

It is the policy of Community Health Centers to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon household income and size. A "**Family**" is one or more persons living in one dwelling place who are related by blood, marriage, or law. Adults and minor children are considered a family. **Relatives over 18 (that are not full-time students) are not eligible to be used as dependents for this application process.** Please complete the following questions to determine if you or your family members are eligible for our sliding scale program. *Es la política de Community Health Centers, Inc. de proveer los servicios esenciales sin tener en cuenta la capacidad de pagar del paciente. Descuentos son ofrecidos dependiendo del ingreso total y el número de familiares que vive en la casa. Una "familia" se refiere a las personas que viven en un domicilio y son parientes por sangre, matrimonio o ley. Se considera adultos y sus menores una familia pero no se puede usar, como dependientes, parientes mayor que los 18 años (que no son estudiantes de jornada completa) para esta solicitud. Por favor responda a las siguientes preguntas para determinar la elegibilidad de usted o uno de los miembros de su familia para nuestro programa de descuentos.*

<u>Household Member's Name:</u> <i>Nombre de miembros en su hogar</i>	<u>Date of Birth:</u> <i>Fecha de nacimiento:</i>	<u>Weekly</u> <i>semanal</i>	<u>Monthly</u> <i>mensual</i>	<u>Annual</u> <i>anual</i>
SELF/UNO MISMO _____	_____	_____	_____	_____
SPOUSE &/or PARTNER CÓNYUGE O PAREJA _____	_____	_____	_____	_____
CHILD/ HIJO /A _____	_____	_____	_____	_____
CHILD/ HIJO /A _____	_____	_____	_____	_____
CHILD/ HIJO /A _____	_____	_____	_____	_____
CHILD/ HIJO /A _____	_____	_____	_____	_____
Total Calculated Annual Income:				\$ _____
<i>Ingreso total anual</i>				

The total number of family members living in your household (Working and Non-Working): _____
 Numero total de miembros de familia viviendo en su casa (con empleo y sin empleo)

NOTE: Include income from all sources from Adults listed above. These include, but are not limited to: gross wages, tips, social security, disability, pensions, annuities, veterans payments, net business or self employment, alimony, child support, military, unemployment public aid and any other form of income. *¡Ojo! Incluye el ingreso de todos los adultos de la familia y de todos los medios posibles. Los medios pueden incluir: sueldos, propinas, seguro social, invalidez, subsidios, anualidades, pagos de veteranos, auto-empleo, pensión alimenticia, ayuda de niños, desempleo, asistencia pública, y más.*

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

I certify that the above facts are true and correct to the best of my knowledge. I am also aware that this information may be randomly audited at any time for verification purposes. Knowingly providing false information may result in termination of services. *Yo certifico que la información dada en el presente es correcta y verdadera. Entiendo que se puede auditar esta información en cualquier momento para propósitos de comprobación. También entiendo que la presentación de información falsa podrá resultar en la terminación de servicios.*

 Signature of Applicant / *Firma del solicitante* _____
Date/ *Fecha*

 Signature of Financial Counselor Operator # _____
Date

Patient Name: _____ Chart # _____ Date of Interview: _____



Sliding Scale Agreement & Acknowledgement

Patient Name: _____ Date: _____

Account #: _____

With the information you presented today it has been determined that you qualify for the Sliding Scale _____ Plan. This plan is in effect until _____, _____. After this date you will need to bring in updated income to re-apply for this program. If your income changes during this time or if you obtain health insurance coverage, you must notify us immediately.

At this time you will be responsible for:

- _____ Sliding Scale A (\$20 for Medical provider visits/\$25 for Dental Provider visits))
- _____ Sliding Scale B (25% of all services)
- _____ Sliding Scale C (50% of all services)
- _____ Sliding Scale D (75% of all services)
- _____ Sliding Scale E (100% of all services)
- _____ Sliding Scale F (100% of all services)

Please keep in mind that if any procedures are done during your visit (Labs, EKG, X-Ray, etc), this will result in an additional charge.

Payment is expected at the time of service. If you have any questions, please ask to speak to a staff member.

I certify that the above facts are true and correct to the best of my knowledge and that I understand the financial responsibilities associated with the Sliding Scale Plan _____. I am also aware that this information may be randomly audited at any time for verification purposes. Knowingly providing false information may result in termination of services.

Signature of Applicant

Date

Signature of Financial Counselor

Date