Coal Country Community Health Center

SLIDING FEE SCALE APPLICATION

Applicant Information

Name: First, MI, Last	Social Security Number	Date of Birth	County
Address:	City/State/Zip	Phone Number	Email Address

Please include information for yourself and all other individuals in the household for whom you are responsible for medical expenses regardless of insurance status: NOTE: (DO NOT list individuals for which the applicant is not LEGALLY responsible for medical expenses) **If additional space is needed, please attach a separate document

NUMBER OF HOUSEHOLD MEMBERS: _____

Adult Name	DOB	Relationship	Insurance	Income	Employed
		SELF	Y / N	$	Y / N
			Y / N	$	Y / N
			Y / N	$	Y / N

Child/Dependent Name	DOB	Ins?	Child/Dependent Name	DOB	Ins?
		Y / N			Y / N
		Y / N			Y / N
		Y / N			Y / N

Please include information/documentation for all adult family members who are employed. Income information must be provided within 30 days of your appointment with CCCHC, otherwise services will be rendered without discount.
If your income is $0, how are you meeting your food, clothing, shelter, and transportation needs?

Employed Person	Company Name	Income (Pre-Tax)	Paid how often? (Check one)
		$	☐ Weekly ☐ 2 times/month ☐ Monthly ☐ Every 2 weeks
		$	☐ Weekly ☐ 2 times/month ☐ Monthly ☐ Every 2 weeks

Other Sources of Income:	Alimony $	SNAP/TANF $	Pension/Retirement $
Unemployment $	Disability $	Social Security $	Self-Employment $
Child Support/Alimony $	Other $	Other $	Workers' Comp $

See back page for acceptable documentation and verification of no income →

Coal Country Community Health Center offers a dental voucher program to our Sliding Fee Patients.
☐ **Yes, I am interested in learning more about the sliding fee dental program through CCCHC**

Please read carefully before signing:

I agree to pay my nominal fee of up to $10 due at the time of check-in for appointments with a provider, and I believe this nominal fee is reasonable for the services and discount provided through the Sliding Fee Scale Program. I also understand that any labs processed at Coal Country Community Health Center will qualify for the SFS, but any lab work that is sent to an outside lab for processing will be my financial responsibility. By signing below, I agree that Coal Country Community Health Center (CCCHC) staff may contact each employer listed and/or other agencies to confirm my income. Within 30 days, I will give CCCHC a copy of all information asked for, for all people in the home to see if I qualify for reduced fees. I will be asked to reapply for the program on an annual basis. **I agree to inform CCCHC of changes to my income, family size, or insurance coverage.**

X_____ _____
Applicant Signature Date

_____ _____
CCCHC Financial Counselor Signature Date

_____ _____
CCCHC Financial Counselor Signature Date

For CCCHC Use Only: Poverty Level:_____ Income:_____ Effective Date:_____ Expiration Date:_____

INCOME VERIFICATION INFORMATION

SOURCES OF INCOME	ACCEPTED DOCUMENTATION	SOURCES OF INCOME	ACCEPTED DOCUMENTATION
WAGES – Income received from employment	*Last Federal Income tax return, last **two** paystubs prior to the signature date on this application OR letter from employer stating average hours/wages paid for new employment*	**Public Assistance (TANF), Food Stamps/SNAP**	*Award Letter(s) listing amount received in the current year.*
		SSI/Disability	*Award Letter(s) listing amount received in the current year.*
		Workers' Compensation	*Benefit Award Letter for the current year*
Unemployment Compensation	*Benefit Award Letter for the current year*	**Child Support, Alimony**	*Divorce Decree stating child support or alimony received*
		Assistance from Family/Friends	*A statement from family or friends explaining any financial help they provide you*
Self-Employment Income	*Ledger or income and expenses for the current year or prior year income taxes*	**Retirement/Pension**	*Letter supplied by system administrator with monthly benefit amount for the current year*

CCCHC requires proof of income or no income for those applying for the Sliding Fee Scale Program. Please use the form below as proof of **no** income if the above sources of income do not apply to your household**. A 3rd party signature is required by an adult 18 or older to verify the applicant is unemployed and not collecting any income at this time. Please have a 3rd party sign below.**

Verification of No Income Received

Name of Applicant:_____ **Date:**_____
(Please Print)

Name of 3rd Party:_____
(Please Print)

3rd Party Phone Number:_____

I certify to my best knowledge that _____, a patient at CCCHC, has no income at this time.
(Print name of applicant)

X_____ _____
3rd Party Signature Date

X_____ _____
Applicant Signature Date