Sliding Fee Discount Program Application

Patient Name: _____ Date: _____

Guardian Name (*if applicable*): _____

Street Address: _____ City, ST: _____ Zip: _____

Phone Number: _____ Email Address (*optional*): _____

1. Are you claimed as a dependent on a relative's income taxes? a. ***Note:*** *If you are claimed as a dependent on a relative's income taxes, you cannot apply; the person claiming you must apply using his/her information.*	☐ Yes	☐ No
2. Who is employed in the household?	☐ Self ☐ Spouse	☐ Both
3. Have you applied for Medicaid or had Medicaid coverage in the past year?	☐ Yes	☐ No
a. Are you under the age of 21, pregnant, or the primary caretaker of a child living in the home under the age of 19?	☐ Yes	☐ No
4. Are you age 65 or older?	☐ Yes	☐ No
a. Have you applied for Medicare?	☐ Yes	☐ No
b. Are you receiving Social Security Disability?	☐ Yes	☐ No
c. Have you recently been disabled, or will you be disabled for 12 months?	☐ Yes	☐ No
5. Are you legally blind?	☐ Yes	☐ No
6. Are you a veteran?	☐ Yes	☐ No
a. Have you applied for VA benefits?	☐ Yes	☐ No

Please list all family members, including yourself, who live in your household or are claimed as dependents for tax purposes.

Name	Date of Birth

Total household size: _____ **Total family income:** $_____

I HEREBY CERTIFY THAT THE INFORMATION SUBMITTED IS TRUE TO THE BEST OF MY KNOWLEDGE. I give permission to Advance Community Health to contact any individual who may have information regarding my eligibility. I declare, under penalty of perjury, that the information on this form, my Federal Income Tax Return, and the accompanying documentation submitted with this application, is true, correct, and complete. If it is determined that any of the information provided is inaccurate or if I fail to immediately notify Advance Community Health of any changes, I understand that I shall be removed from the Sliding Fee Discount Program, and that I shall be responsible for all charges retroactive to the date the information was found to be inaccurate, and that I may no longer be able to receive discounted care from Advance Community Health. I understand that I may revoke this authorization at any time by notifying the providing organization in writing.

Patient name	Patient or parent/guardian signature	Date
Printed name *(if signed on behalf of the patient)*	Relationship *(if signed on behalf of the patient)*	Date
ACH Employee name	ACH Employee Signature	Date
ACH Employee Witness name	ACH Employee Witness Signature	Date