SPECIALTY CLINIC
SLIDING FEE/ CAPS ON CHARGES PROGRAM

The purpose of this form is to document eligibility for our sliding scale fee program and caps on charges. As part of our federal grant assistance, this form helps provide you with primary health care and support services. Our center is required to ask you the following information and collect verification documentation regarding income, insurance status, and housing. This form is valid for 12 months after the screening date. All information is kept confidential and used only for the purposes of determining program eligibility.

Patient Name: _____ Social Security#: _____
Last First Middle

Address: _____

_____
City State Zip Code

Phone Number: (cell) _____ (home) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Housing Status:

☐ Permanent housing ☐ Temporary Housing ☐ Homeless ☐ Emergency Shelter

☐ Living with friends/ family ☐ Incarcerated

Household size: _____

Household size: Family/household is defined per grant guidelines, including related individuals, same-sex couples, and common law households. Roommates and unrelated individuals are not considered part of the household for income determination.

	Name	Date of birth
1.		
2.		
3.		
4.		
5.		
6.		

7. _____

8. _____

HOUSEHOLD INCOME (List ALL household income for all adult household members):

	Total for 12 months
Gross Wages, Salaries, Tips	$_____
Social Security	$_____
Disability	$_____
Farm/Self-Employment Net Earnings	$_____
Unemployment	$_____
Public Assistance (exclude food stamps)	$_____
Workers' Compensation	$_____
Alimony	$_____
Child Support	$_____
Military	$_____
VA Benefits	$_____
Pensions/Annuities	$_____
Dividend or Interest Income	$_____
Rental Income	$_____
Total	$_____

PROOF OF INCOME IS REQUIRED FOR EACH ADULT MEMBER OF HOUSEHOLD.

Examples of acceptable proof of income are:

- W-2 Form or most current pay stubs for the last month of employment
- Current tax return
- Unemployment, Social security, Disability, Workers' Compensation award letter
- Child support and/or alimony award letter
- Pension or retirement income information
- Letter from employer establishing income
- Letter from person/persons supplying support showing amount and frequency of support

Does patient currently have any medical insurance? Yes_____No _____

Health Insurance:

☐ Private- Employer ☐ Private- Individual ☐ Medicare ☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid

☐ VA/ Tricare (Military) ☐ No insurance/ uninsured ☐ Other:_____

Does patient currently have any dental insurance? Yes_____No _____

Employment status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Student

If you had a change in financial circumstance since your last application, please provide documentation of current income or financial status and write a note explaining how it has changed.

_____

_____

_____

I affirm that the above information is true and correct.

_____ _____

Signature of Patient Date

For Office Use Only

This document was received on _____ By _____

Rate approved per table_____ Reapply by _____

Federal Poverty Level: ☐ Below 500%- At or below $75,300.00 ☐ Over 500% at or above $75,300.01

Eligibility: ☐ Eligible for Specialty Services ☐ NOT eligible for Specialty Services