Community Health Care, Inc.

Chart #s:

Annual Sliding Fee Application

Sliding Fee Discount	Would you be interested in seeing if you qualify for a discount on our services? ☐ Yes ☐ No

Community Health Care offers a sliding fee discount to all our patients, regardless of Insurance coverage. The sliding fee discount gives you a discount on your services and is based on your household size and income. This discount will be applied to your balance after you meet your co-pays and Insurance payments are made. To qualify for a sliding fee discount, you must fill out the application at a minimum of once per year.

Your sliding fee discount can be used at any of our locations

If you selected **YES** for the discount, does **ANYONE** in your household receive:

☐ Employment Income ☐ Unemployment Income

☐ Social Security of Disability ☐ Retirement or Pension

☐ Child Support or Alimony ☐ State or Federal Cash Assistance

☐ Rental Property Income ☐Other/Cash Income _____

Who receives income? ☐ Yourself ☐ Spouse/Significant Other ☐ Other: _____

Decline of Sliding Fee discount

Patient has verbally declined the Sliding Fee Discount.

Patient Signature _____Date_____ or if unable to sign Staff Initials _____

Self-Declaration for discount

Patients current household income is $_____(annually).

Patient Signature _____ Date_____ or if unable to sign Staff Initials _____

HOUSEHOLD SIZE

Chart # (office use)	Name of Family Members (living in your household)	Date of Birth	Gender	Insurance
	Yourself:		☐ Female ☐ Male	☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ None
	Spouse/Significant Other:		☐ Female ☐ Male	☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ None
	Child (under 18): Relation:		☐ Female ☐ Male	☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ None
	Child (under 18): Relation:		☐ Female ☐ Male	☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ None
	Child (under 18): Relation:		☐ Female ☐ Male	☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ None
	Child (under 18): Relation:		☐ Female ☐ Male	☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ None

Office Use Only

Gross Household Income $_____ (Annually) Family Size _____ Sliding Fee Percentage _____

Effective Start Date _____ Effective End Date _____ PSP/Intake Initials_____/_____