Community Health Care, Inc.

Chart #s:

Annual Sliding Fee Application

Sliding Fee Discount	**I declare that my household has been working and/or receiving income in the amount of $_____ per (circle one) day, week, bi-weekly, month or annually.**
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.	Where does your household receive their income from? ☐ Employment Income ☐ Unemployed or No income ☐ Social Security or Disability ☐ Retirement or Pension ☐ Child Support or Alimony ☐ Unemployment Income ☐ Rental Property Income ☐ Other/ Cash Income ☐ State or Federal Cash Assistance **Who receives income?** ☐ Yourself ☐ Spouse/Significant Other ☐ Other: _____

Decline of Sliding Fee discount

You have **declined** our sliding fee discount. By signing this form, you are stating that you **do not** want our sliding fee discount. You may sign up for the discount at any time, however, you will not be asked to apply again for a year from today's date.

Patient Signature _____Date_____ or if unable to sign Staff Initials _____

Self-Declaration for discount

I understand my information may be subject to verification by Community Health Care, Inc. I certify that the information present on this form is true and correct to the best of my knowledge and belief.

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

Chart # (Office use)	Name of Family Members (Living in your household)	Date of Birth	Relation	Insurance
	Yourself:			☐ Private Insurance ☐Medicaid ☐ Medicare ☐ None/U
	Spouse/Significant Other:			☐ Private Insurance ☐Medicaid ☐ Medicare ☐ None
	Child's Name (under 18):			☐ Private Insurance ☐Medicaid ☐ Medicare ☐ None
	Child (under 18):			☐ Private Insurance ☐Medicaid ☐ Medicare ☐ None
	Child (under 18):			☐ Private Insurance ☐Medicaid ☐ Medicare ☐ None
	Child (under 18):			☐ Private Insurance ☐Medicaid ☐ Medicare ☐ None
	Child (under 18):			☐ Private Insurance ☐Medicaid ☐ Medicare ☐ None

Office Use Only

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

Effective Start Date _____ Effective End Date _____ Staff Initials_____