Sliding Fee Scale Discount Program Application

How Does the Sliding Fee Scale Discount Program Work?

As a Federally Qualified Health Center (FQHC), Christian Community Health Center (CCHC), is required to provide a sliding fee scale discount program to patients who meet the eligibility guidelines. To determine if you are eligible for this discount, you will need to fill out & sign this application. The sliding fee scale discount application is used to determine eligibility for the sliding scale and to assess the level of discount assigned to the patient.

In addition to this application, you will need to provide CCHC with the following documents to apply for the sliding fee scale discount:

Proof of income for you and anyone who resides/lives in your home. The following items may be used as proof of income:

- W-2 forms
- Two most current pay stubs
- Income tax returns
- Any other income documentation (i.e. statement of unemployment benefits, social security benefit letter, public assistance benefits letter, etc.)
- If you are not working, and do not have a source of income, a notarized letter of support from someone who is supporting you financially or the individual that you are living with or

Proof of identification will also be required in the form of any two of the following valid and current documents:

- State issued Driver's license
- State issued identification card
- Birth certificate (if born in the U.S.A.)
- Marriage license (if name verification needed)
- Employment identification badge
- Illinois Medicaid identification card
- Matricula card
- Utility bill
- Voter's identification card
- Valid passport
- Alien Registration Card (commonly known as a "green card")

Patient Information

Name (First)_____(Last)_____Date of Birth _____

Are you currently employed? ☐YES ☐NO

Is your spouse/partner currently employed? ☐YES ☐NO ☐N/A

Are any other family members, who live with you, employed? ☐YES ☐NO ☐N/A

Household Members & Gross Income (please include other dependents claimed on taxes, children, spouse/partner)

☐ Check here if you refuse to provide proof of income. Please note that you will not be eligible for the sliding fee discount program if you refuse to provide this information

Household Member Name	Relationship to Patient	Date of Birth	Monthly Income (Gross)	Insured? (Yes/No)	Student? (Yes/No)
1.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
2.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
3.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
4.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
5.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
6.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
7.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				
8.	○ Self ○ Spouse/Partner ○ Child ○ Other Dependent				

** Proper proof of income documents must be provided for each household member

Certification

I certify that everything I have reported on this application and attached documents is true and correct to the best of my knowledge. I understand that Christian Community Health Center will verify the information contained within this application. I authorize Christian Community Health Center to contact third party agencies or individuals to verify that the information is correct. I understand that if I reported anything in this application that is false, I will not be eligible for financial assistance, any financial support may be reversed, and I may have to pay back any charges from services I have received.

I also agree and understand that I am responsible for any fees associated with my visit(s) at CCHC.

Patient/Applicant Name (Print): _____ Date: _____

Patient/Applicant Signature: _____

To be completed by the office

Sliding Fee Discount Eligibility Identification

Based on your household size & income information provided, you were found eligible for the following sliding fee discount program:

		Medical/Behavioral Health	Dental
	Level 1	$25, per person, per visit	$35, per person, per visit, per procedure
	Level 2	$30, per person, per visit	$40, per person, per visit, per procedure
	Level 3	$35, per person, per visit	$45, per person, per visit, per procedure
	Level 4	$40, per person, per visit	$50, per person, per visit, per procedure
	Full Price	Full price of office, per person, per visit (Minimum of $75 due at time of check in)	Full price of office, per person, per visit (Minimum of $75 due at time of check in)

_____ _____

Printed Name of CCHC Staff Date

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Signature of CCHC Staff