Sliding Fee Discount Application

How Does the Sliding Fee Scale Work

As a Federally Qualified Health Center (FQHC), Christian Community Health Center, is required to provide a sliding fee discount 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 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 discount:

Proof of income for you and anyone who resides 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, and etc.)
- If you are not working, and do not have a source of income, a letter of support from the sustaining party or individual that you are living with

Proof of identification will also be required in the form of any two of the following:

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

Patient Information

Name(Last)_____(First)_____ (MI) _____

Street Address_____ Apt. #:_____

City_____ State _____ Zip Code_____

Home Phone_____ Cell Phone _____

Date of Birth_____ SS#_____

Are you: ☐ Single ☐ Married/Partner ☐ Widow/Widower ☐ Divorced ☐ Separated

Family size: total number of people living in your house: _____
(dependent children, spouse/partner, parents or in-laws)

Do you have a job right now? ☐ YES ☐ NO

Does your spouse/partner have a job right now? ☐ YES ☐NO

Do any of the other family members who live with you have a job right now?

☐ YES ☐ NO

Are you covered or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veterans' benefit, Medicaid and Medicare? ☐ YES ☐ NO

If yes, please provide the following information:

Policy Holder:_____ Insurer:_____

Policy Number:_____

If you are divorced/separated, is your former spouse/partner financially responsible for medical care? ☐ YES ☐ NO

Household Members & Gross Income (dependent children, spouse/partner, parents or in-laws)

☐ 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	SS Number	Monthly Income	Insured? (Yes/No)	Student? (Yes/No)

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

Sliding Fee Discount Eligibility Identification

Based on the 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)

Certification

I promise that everything I have written on this form is true and right as far as I know. I understand that Christian Community Health Center may make sure that what I have said on this form is true, and I authorize Christian Community Health Center to contact third parties to make sure that the information is right. I understand that if I said anything in this application that is not true, I will not be able to get financial help, any financial help may be reversed, and I will have to pay back any charges.

I agree & understand that I am responsible for any fees associated with my visit.

Patient/Applicant Name: _____ Date: _____

Patient/Applicant Signature: _____ Date: _____

To be filled out by CCHC staff

Check box if verified and obtained

___ Acceptable identification for each family member listed on SFS application

___ All family members names and dates of birth listed on SFS application

___ Acceptable income verification obtained

------ Current Federal Tax Return

____ Last 30 days paycheck stubs

____ Official letters/documents

___ Patient Refused to provide proof of income information

_____ _____

Printed Name/Signature of CCHC Staff Date