Sliding Scale Application

You may be eligible for our Sliding Fee Discount Program if you are experiencing financial difficulties. Please fill out the information below and send in the required documentation within the next 10 days. We will process your application to determine if you qualify for our program.

Applicant Information

Patient Name: _____ Date of Birth: _____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone Number: _____ Social Security No.: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

1. Are you covered under Medicaid, Medicare and/or any other insurance? □ Yes □ No
2. If you have private insurance, what is your annual deductible, per family member? $ _____
3. Have you or your dependents ever applied for or been denied for Medicaid or Medicare? □ Yes □ No
4. Would you like to apply or re-apply for Medicaid today? □ Yes □ No
5. Are you unemployed? □ Yes □ No

Household Size

Household size are those that you claim as dependents on your tax return (or would claim as dependents if you were required to file a tax return), including yourself. If you are claimed as a dependent on someone else's tax return, then your household size is that person and all their dependents, including yourself. If you do not file taxes and are not claimed as a dependent by anyone else, your household is you. Divorced/separated/joint custody parental relationships- dependent children may only be listed on one program application. Financially co-dependent unmarried couples living together with mutual children will be counted as one household. If co-dependent unmarried couple living together with no mutual children, your household will only be you. Adult children living at home who are no longer dependent are considered a separate household. Roommates who share living arrangements, but are not tied to one another through marriage, children, or similar relationship are considered separate households. Those living with a friend or relative during a time of need are also considered a separate household.

Please include yourself, your spouse/partner and all dependents living in the home below:

Full Name	DOB	Relationship	Applying for Sliding Scale	Gross Monthly Income
		Head of Household	□ Yes □ No	$
			□ Yes □ No	$
			□ Yes □ No	$
			□ Yes □ No	$
			□ Yes □ No	$
			□ Yes □ No	$

Proof of Income Documentation

Patients who choose to participate in the Sliding Scale Discount Program are required to provide documentation for each member of household over the age of 18 to verify household income. Refer to the list below and provide the most recent documentation for all income situations that apply.
**If you declare no income – you must complete the 219 Health Network Letter of Financial Support and the supporting person will need to provide any form of documentation listed below. **

Income Source	Frequency	Required Documentation	Additional Forms Needed
Employment with Company/Organization (Salary, Wages, Tips from employment)	Weekly Bi-Weekly Monthly	Two most recent paystubs for the last 30 days **OR** Most recent Tax Return (Signed) & W-2	If paid cash, statement on Letterhead from employer stating hours worked and earnings.
Self-Employment	Weekly Bi-Weekly Monthly	Most recent Tax Return including schedule C **OR** 3 Months of Bank Statements	219HN- Letter of Self Employment
Currently Unemployed	Weekly Bi-Weekly Monthly	Unemployment benefit letter or weekly claims report showing current gross income	
Workers' Compensation Benefits	Weekly Bi-Weekly Monthly	Workers Compensation benefits award letter showing gross distribution	
Short/ Long Term Disability Benefits	Weekly Bi-Weekly Monthly	Most recent pay stubs showing gross income for disability benefits for the last 2 months	
Social Security or Disability Income (SSI/SSDI)	Weekly Bi-Weekly Monthly	Current year award letter **OR** Most Recent Tax Return (Signed) & W-2	
Retirement Benefits (Pension)	Weekly Bi-Weekly Monthly	Benefit Letter or Statement showing Gross amount distributed **OR** Most Recent Tax Return (Signed) & W-2	
Temporary Assistant for Needy Families (TANF)	Weekly Bi-Weekly Monthly	Benefit Determination Letter	
Alimony or Child Support	Weekly Bi-Weekly Monthly	Record of Payments received (bank statement, copy of check, etc.) or copy of court order	
No Income	Weekly Bi-Weekly Monthly	Two most recent paystubs for last 30 days of supporting person **OR** Most Recent Tax Return (Signed) & W-2	219 HN Letter of Financial Support, Copy of ID of Supporting Person

I CERTIFY THAT:

The information stated in the application is an accurate and complete statement of my financial status. I understand that willful falsification and/or omission of information contained in this application will result in denial. I have declared all sources of income as requested.

I understand that I must re-apply for the sliding fee discount program every 12 months and I agree that it is my responsibility to notify 219 Health Network of any changes in annual income, family size and other circumstances anytime during the approved year. I also understand that if I/we do not agree with any decision regarding this application, we have the right to request the application and the decision be reviewed by 219 Health Networks Chief Executive Officer or his/her designee.

Signature: _____ Date: _____