Sliding Fee Scale Application
United Community Health Center

Application Introduced By: _____ ***Date:*** _____ ***Due Date:*** _____

Patient's Full Name _____ Date of Birth _____
Address _____ Apt/Lot # _____ Home Phone # _____ Cell _____
City _____ State _____ Zip Code _____
Responsible party's Name _____ DOB _____ Phone _____

Have you or any of your household members applied for Medicaid (Title XIX) Yes □ No □ When /Who _____
Please list all household members, including you, below:

MR#	First & Last Name	Date of Birth	Social Security #	Income Source	Relationship

Please indicate which of the following income sources your household receives, who receives it and how often it is received:

			Who	How Often				Who	How Often
Yes	No	Employment			Yes	No	VA Benefits		
Yes	No	Child Support			Yes	No	Rental Property		
Yes	No	Unemployment			Yes	No	SS,SSI,SSD		
Yes	No	FIP/Welfare			Yes	No	Worker's Comp		
Yes	No	Pension			Yes	No	Self-employment		
Yes	No	Alimony			Yes	No	Cash Wages		
Other:									

You are required to provide proof of above listed income in order to complete your application. The following are acceptable forms of income:

- Current Federal Income Tax (1040-1040 EZ)
- Current Bank Statement or Print out from SSI office
- Current Paystubs for recent month
- Employer statement for cash wages (must include employer name, address, and phone #)
- Letter from Caregiver

I declare that my household's financial status is as listed above. I realize that United Community Health Center is utilizing federal tax dollars to assist me in receiving health care. I understand that giving false information regarding my household income is considered fraud against the United States government. Note: not all lab services are covered by the sliding fee program. Please ask your provider if your services are covered under the program prior to agreeing to any testing.

Applicant Signature _____ Date _____

Date SFS application Received: _____ ***By:*** _____

Guarantor# _____