APPLICATION FOR SLIDING FEE SCALE DISCOUNT

Christ Community™ HEALTH SERVICES

Name:	Date:
Social Security Number:	Date of Birth: (mm) / (dd) / (yyyy)

INSURANCE

Do you, or the patient you represent, have medical insurance? Yes ☐ No ☐ Dental insurance? Yes ☐ No ☐

If YES, you may still qualify and pay the lesser of your insurance portion or the Sliding Fee. Please provide your insurance card at the front desk.

APPLICANT AFFIDAVIT

I certify that the information on this application is true and accurate. I understand that it is my responsibility to complete the application and provide the required proof of income documentation and identification for everyone in my household within two weeks of the date of this application in order to be eligible for discounted services.

I agree to inform Christ Community Health Services if my financial situation changes significantly. I also understand that falsifying information or documentation on the application will result in my application being denied and any applicable discounts received under false pretenses will be revoked and I will be responsible for all charges.

I understand that this application, and any discount that I may qualify for, will apply only to the patient listed on this application. Any/all additional patients would need to apply separately.

I am aware that CCHS is regulated by policies and regulations established by the federal government, and it is considered unlawful to misrepresent or falsely claim inaccurate information on this application.

I agree to assist CCHS in any way I am asked to check any information on this application, and let them get needed information from employers, government agencies, medical providers, and other sources.

Name of Applicant	Date

Determine the Number of People in Your Household

To Be Completed by the Head of the Household

Relationship	Include	Do Not Include	Number
Yourself			1
Your spouse	Include if you are legally married, regardless of sex. Include if you are legally married but living apart (for example, spouse is away on military duty, away on work, or away for some reason other than legally separated or divorced).	Do not include if you are legally separated or divorced. You do not need to claim your spouse if you are a victim of domestic abuse, domestic violence, or spousal abandonment.	
Child(ren)	Include number of dependent children under the age of 21. Include adopted and foster children living with you that you can claim as a dependent. Include the number of children you with whom you share custody if you can claim them as a dependent.	Do not include if a child is a non-dependent. Do not include if a child is unborn.	
Other dependents	Include the number of parents you claim as dependents. Include the number of siblings and other relatives who you claim as dependents.	Do not include unmarried domestic partner. Do not include roommates.	
		Total Household Members (add right column)	

SLIDING FEE SCALE REGISTRATION REQUIREMENTS

Proof of identification:
Please bring one of the following identifications (if it is not currently on file).

- Social security card
- Valid driver's license or current state ID
- Birth certificate
- ITIN card (individual tax identification number) or ITIN assignment document
- Passport

PROOF OF INCOME

As a Federally Qualified Health Center (FQHC), Christ Community Health Services (CCHS) is able to provide sliding fee discounts for self-pay and underinsured patients who meet income eligibility requirements. Self-pay and underinsured patients may qualify for the discount program based on family size and proper documentation of all household income.

<table>
<tr><th>Income</th><th>Verification</th><th>Amount</th></tr>
<tr><td>IRS Form 1040, 1040A, or 1040EZ from prior year.</td><td>Form 1040 – Line 22
Form 1040A – Line 15
Form 1040EZ – Line 6</td><td></td></tr>
<tr><td colspan="2">If you do not have your tax form, you can request a copy of the return transcript by calling the IRS at 1-800-829-1040
or online at: www.irs.gov/Individuals/Get-Transcript
or submit a 4506-T with a non-refundable $5 convenience fee.

If you do not have your tax form, ALL forms of verification below for ALL household members are required.</td><td></td></tr>
<tr><td>Wages, salaries, tips, etc.</td><td><table><tr><th>If you are paid:</th><th># of Stubs</th></tr><tr><td>Weekly</td><td>4</td></tr><tr><td>Bi-Weekly (every 2 weeks)</td><td>2</td></tr><tr><td>Semi-Monthly (1st and 15th)</td><td>2</td></tr><tr><td>Monthly</td><td>1</td></tr><tr><td>Self-employed</td><td>Prior Year 1099s</td></tr></table></td><td></td></tr>
<tr><td>Alimony</td><td>Most recent month's check stubs</td><td></td></tr>
<tr><td>Unemployment compensation</td><td>Most recent month's check stubs</td><td></td></tr>
<tr><td>Social Security benefits</td><td>Most recent year's award letter from the SS Administration or bank statement showing direct deposits from the SS Administration</td><td></td></tr>
<tr><td>IRA or retirement plan distributions</td><td>Most recent month's check stubs</td><td></td></tr>
<tr><td>Interest, dividends, rental income</td><td>Most recent Form 1040</td><td></td></tr>
<tr><td>Business Income</td><td>Most recent Form 1040</td><td></td></tr>
<tr><td>Capital gains</td><td>Most recent Form 1040</td><td></td></tr>
<tr><td colspan="2">Total Household Income (add right column)</td><td></td></tr>
</table>

How will you provide proof of your income (please check one):

☐ I will provide proof of income today.
☐ I will bring proof of income within 2 weeks. Otherwise, I will receive a full bill.
☐ I will submit Form 4506-T for an IRS Transcript. I consent to pay a non-refundable $5 convenience fee.
☐ I do not have any verifiable income, and I do not have a Social Security or Tax Identification Number.

Signature _____ Date _____