Sliding Fee Discount Schedule Program Application

Patient Information			Today's Date: / /		
First Name:	Middle:	Last:	Other names:		
Home Address:		City:	State:	Zip:	
Mailing Address:		City:	State:	Zip:	
Home Phone #: ( ) -		Cell Phone #: ( ) -			
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No		
Marital Status:	Single	Registered Domestic Partner	Married	Divorced	Separated Widowed

Note: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Your yearly income W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

By signing below you authorize RUHS-Community Health Center to verify your information related to income and family size.

Household Size	Relationship	Date of Birth	Social Security Number
Name			
		/	- -
		/	- -
		/	- -
		/	- -

Household Income					
Name	**Amount**	**Frequency (Circle one)**	**Employer:**	**Employer Address**	**Years Worked**
You	$	Weekly Monthly Yearly			
Spouse	$	Weekly Monthly Yearly			
Children	$	Weekly Monthly Yearly			
Other	$	Weekly Monthly Yearly			
	$	Weekly Monthly Yearly			
TOTAL	$	Weekly Monthly Yearly			

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Child Support, Alimony					
Interest Income					
Other					
Social Security				TOTAL	$

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the Sliding Fee Discount Schedule Program, and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform RUHS-Community Health Center if there is a significant change in my income. If acceptance to the Sliding Fee Discount Schedule Program is obtained under this application, I will comply with all rules and regulations of RUHS-Community Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:____________________ Name (Print):______________________________________

Signature (Patient/Parent/Guardian):____