RIVERSIDE UNIVERSITY HEALTH SYSTEM – COMMUNITY HEALTH CENTER

ACKNOWLEDGEMENT OF RECEIPT OF
SLIDING FEE DISCOUNT SCHEDULE PROGRAM INFORMATION

As a Health Center Program grant recipient from the U.S. Department of Health and Human Services, Bureau of Primary Health Care, the Riverside University Health System – Community Health Center ("RUHS-CHC") offers a Sliding Fee Discount Schedule ("SFDS") Program that provides eligible patients a discount based solely on their income and family/household size.

SFDS Program applications are available at the Front Desk and on the RUHS-CHC website. All patients are encouraged to apply regardless of insurance status. Proof of total household income must accompany the completed and signed application. Family household income includes all income from each person sharing the same physical address and same income.

Examples of acceptable proofs of income:

- W-2 Form, Current pay stub, Bank statement showing direct payroll deposits
- Unemployment, Social security, Disability, Workers' Compensation award letter
- Child support and/or alimony award letter
- Pension or retirement income information
- Letter from employer establishing income
- Signed Self-Declaration Form

Once a completed application with proof of income is received, a determination will be provided to the patient(s) in writing, including the eligible discount category, or if applicable, the reason for denial. Qualified patients must pay at the time of service unless other arrangements are made with the Billing Department.

Please initial beside each item that you have received either a verbal explanation or documents relative to the SFDS Program.

_____ RUHS-CHC Sliding Fee Discount Schedule Program Application

_____ RUHS-CHC Sliding Fee Discount Schedule

_____ RUHS-CHC Sliding Fee Discount Schedule Program Brochure

Your RUHS-CHC assigned Slide Category is: ____, and your Fixed Payment Amounts are as follows:

Medical $____, Dental Preventative: $____, Dental Restorative: $____, Pharmacy: $____

_____
Patient's Name (Print)

_____ _____
Signature (Patient/Parent/Guardian) Date

Form Revised 06/15/2018