Hope Christian Health Center

Proof of Income Due: _____

Dependent(s): _____

Slide: _____

Application for Sliding Fee Scale Program

Patient Name: _____ Phone Number: _____

☐ I have been given the opportunity to apply for the HCHC Sliding Fee Scale Program, and ***I do not wish to apply for the HCHC Sliding Fee Scale Program at this time.***

Patient Signature: _____ Date: _____

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical, behavioral health, and/or dental needs. ***This information will not be used to withhold or deny services to you.***

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 Nevada Medicaid today?	Yes	No
5.	Are you unemployed?	Yes	No

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

Name	Date of Birth	Age	Relationship to Head of Household
			Head of Household

Income Verification

Please enter your ***gross income*** (the dollar amount received before taxes are taken out). Household income includes ***everyone*** in the home. Proof of income includes: most recent tax return, check stubs, bank verification, a letter from the employer stating wages earned, or proof of unemployment.

If there is ***no income to report, or if you do not want to comply with documentation requirements***, you must complete the reverse side of this application.

How are you paid?	Circle One	Amount	Office Use Only
Work Wages	Weekly / Bi-Weekly / Monthly / Other	$	Staff Signature: _____
Cash Wages	Weekly / Bi-Weekly / Monthly / Other	$	Staff Name: _____
Disability	Weekly / Bi-Weekly / Monthly / Other	$	Date: _____
Social Security	Weekly / Bi-Weekly / Monthly / Other	$	Discount Scale & Rate: _____
Unemployment	Weekly / Bi-Weekly / Monthly / Other	$	Patient Advised of Discount Rate: _____ Initials
Worker's Compensation	Weekly / Bi-Weekly / Monthly / Other	$	
Other Income _____	Weekly / Bi-Weekly / Monthly / Other	$	

Please Refer to the Current HCHC Sliding Fee Discount Slide Schedule

Patient Acknowledgment Statement

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify HCHC. I understand that I will be financially responsible for ***all or a portion of my care*** and that I will be asked to ***submit payment at the time of service***. I authorize the release of any information necessary to establish my family's eligibility for discounted services.

Patient Signature: _____ Date: _____

Declination Statement (for patient's who do not want to comply with sliding scale requirements)

Because you do not wish to apply or comply with the requirements to apply for our sliding scale discount, you are choosing to be a self pay patient. This means that you will pay ***$200.00*** up front at the time of service and you will be responsible for any and all balances due after the provider's charges for your visit are entered. You will also be responsible for any lab and/or x-ray charges for today's visit. Any discount for office charges or lab charges are not applicable and you will not be allowed to receive a discount for these charges in the event that a future sliding fee scale application is completed.

Patient Signature: _____ Date: _____

Complete Below for Self-Declaration of Income

Please complete the information below only ***if you have no other way to document your income***. All of the boxes below must be checked and all the questions answered. Failure to complete this information will result in in denial of your application for a sliding fee scale discount.

- ☐ I get paid in cash.
- ☐ I do not get pay checks.
- ☐ I do not get pay stubs.
- ☐ I cannot get a letter from my employer. Explain why: _____

_____

My cash income is: $ _____ How often? (Circle one): Weekly / Bi-Weekly / Monthly / Other: _____

Patient Certification Statement

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the HCHC Sliding Fee Scale Program. I understand that HCHC officials may verify information on this form.

Patient Signature: _____ Date: _____

Patient Name: _____

Employee Certification Statement

I certify that I asked the applicant/recipient about all the sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Employee Signature: _____ Date: _____

Employee Name: _____