COMMUNITY HEALTH CENTERS OF GREATER DAYTON
SLIDING FEE DISCOUNT APPLICATION

Patient Name____ Date of Birth___________________________

Applicant Name (if not patient)_____________________________ Relationship to patient__________________

Street___________________________ City_________________ State_________________________________

Zip Code____________ Phone______________________ Alt or Cell Phone______________________

Please provide the following information for **all people in your immediate family who live in your home.** For purposes of assistance, family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adopted) who live in the patient's home, or that you are legally responsible for. Also please add the number of children that child support is being paid for that do not live in the home

Name	Relationship to Patient	Annual/Monthly or Weekly *INCOME*	Gross Amount

Total # of persons in Family__________ Total # of children child support is paid on, but not living in home_________

Documentation of No Income: If you report $0 income, please explain below how you are surviving without income.

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By my signature *below* I attest that **I have an annual income of $0**

Patients Signature___________________________ CHCGD Witness______________________________

Acceptable forms of proof of income: two check/paystubs, recent tax return or W-2, public assistance or Social Security letter, Child support, alimony, unemployment, Medical Assistance or Dept. of Social Services Certification Letter. (**Include all Income**)

I understand that I must update this information if my situation changes and that a new Discount Application must be completed at least every twelve (12) months. I have received information explaining the program and I understand and agree to abide by the terms. I understand that if I am a self-pay patient; **I** am responsible to pay at least $20 for each medical visit and/or $40 for each dental visit. If an unpaid balance exists on my account after applying my Discount percentage, I agree to make payment arrangements and honor the terms. I understand that if I am unable to make a payment in any given month; I must contact the Billing Office prior to the due date to discuss my need to modify my payment arrangement.

Certification: I certify that the family size and income information shown above is correct**. I understand that documentation supporting my financial position is required before my discount can be approved and that I must provide this information within 30 days or prior to my next visit if sooner.**

_________________________ ___________________________________ ______________________________

Patient Name (print) Signature of Patient or Guarantor Date of signature

Do NOT sign this page if you wish to be considered for a discount. Signing below will void the other side of this form

WAIVER:

I choose not to complete the Sliding Scale Application at this time. I am waiving my right to any Discount to which I may other wise be entitled. I understand that I will be responsible for full payment of all charges at the time of service.

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Patient Name (Please print)	Signature of Patient or Guarantor	Date