Family First Health Sliding Fee Discount Program Application

Family First Health is a nonprofit community health center. We receive money from many different sources so we can provide your medical and dental care based on your family size and income. In order for you to receive a reduction to your bill, we need you to complete the following information and provide proof of your household income. *We will be updating this income information once or twice a year.*

If you believe your household income is too high to qualify, please check here. _____

Last Name, First Name Of all household dependents	**Relationship**	**Does this person have Medical Insurance?** Please Circle	**Monthly Income**	**Date of Birth**	**Acct # FFH staff use only**
	Self	**Yes / No** If yes, list:			
	Spouse (legal)	**Yes / No** If yes, list:			

**List children/dependents on back of application*

Household Address: _____ Apt.:_____

City: _____ State: _____ Zip: _____

Phone: _____ What company do you work for_____

- **Do they offer insurance?** *(please circle)* **YES** or **NO**

If this is your first visit, you will receive a discount based on the information provided to us verbally. In order to continue this discount you must provide proof of income. If income information is not provided, you will not be eligible for the discount. Please mail or bring one of the following proofs of income to Family First Health <u>before</u> your next visit.

-Pay stubs for each household member working: **2 pay stubs if paid bi-weekly* **4 pay stubs if paid weekly*	-Unemployment checks
-Checks for alimony or child support	S.S.I. Checks *(one month or letter)*
-Worker's Compensation check	Tax return or W-2
-Other sources of income not listed above	Tax return & Schedule C *(if self-employed)*

I hereby certify that all information given on this application is correct and completed to the best of my knowledge. Permission is granted for Family First Health to verify any information needed to determine my eligibility. I understand that otherwise, all information is confidential and will only be used in connection with enrollment in the Reduced Fee Program. **I UNDERSTAND THAT ONLY COMPLETED APPLICATIONS WITH APPROPRIATE INCOME ATTACHED WILL BE ACCEPTED. ALL OTHERS WILL BE RETURNED.**

_____ _____

Patient Signature Date

Last Name, First Name Of all household members	**Relationship**	**Does this person have Medical Insurance?** Please circle	**Monthly Income**	**Date of Birth**	**Acct # FFH staff use only**
	Dependent Child #1	**Yes / No** If yes, list:			
	Dependent Child #2	**Yes / No** If yes, list:			
	Dependent Child #3	**Yes / No** If yes, list:			
	Dependent Child #4	**Yes / No** If yes, list:			
	Dependent Child #5	**Yes / No** If yes, list:			
	Dependent Child #6	**Yes / No** If yes, list:			

PLEASE DO NOT WRITE BELOW THIS LINE

FOR PATIENT BENEFITS AND ENROLLMENT SERVICES DEPARTMENT USE ONLY
SLIDING FEE DISCOUNT PROGRAM APPROVAL

INCOME AMOUNT $_____ DISCOUNT _____ FAMILY SIZE _____

PRIMARY HOUSEHOLD ACCT #: _____

EFFECTIVE FROM DATE _____

EFFECTIVE THROUGH & REVIEW DATE _____

DATE APPLICATION APPROVED _____

PATIENT BENEFITS REP INITIALS _____

FamilyFirst HEALTH