

# 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 before 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**

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**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** \_\_\_\_\_

