FAMILYFIRST HEALTH

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Please read IMPORTANT INFORMATION on reverse side before completing this form.

Please select **one** of the following options:

☐ **YES, I AM APPLYING** and have attached my proof of income.
(Applications cannot be processed without income documentation; see reverse for acceptable documents.)

☐ **NO, I AM NOT APPLYING** because I believe my household income is too high.

☐ **NO, I AM NOT APPLYING** and decline to provide income information.

Home Address: _____ **Apt:** _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: (____) ____-_____ **Best Time to Call:** _____ **Email Address:** _____

☐ **Please check here if currently Homeless.**

HOUSEHOLD SIZE AND INCOME

Number of household members (including yourself)**:** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

If more than six, please specify: _____

Last Name, First Name	**Household Member Relationship**	**FFH Patient**	**Does this person have Medical Insurance?** Please Circle and list details	**Gross Monthly Income** (before taxes)	**Date of Birth** mm/dd/yyyy	**Acct# FFH Staff use only**
	Applicant *(Self)*	☒ **Yes** ☐ **No**	**Yes / No** If yes, list:			
	HH Member #2 *Example Spouse* **(** **)**	☐ **Yes** ☐ **No**	**Yes / No** If yes, list:			
	HH Member #3 **(** **)**	☐ **Yes** ☐ **No**	**Yes / No** If yes, list:			
	HH Member #4 **(** **)**	☐ **Yes** ☐ **No**	**Yes / No** If yes, list:			
	HH Member #5 **(** **)**	☐ **Yes** ☐ **No**	**Yes / No** If yes, list:			

**** HH= Household*** ****Additional household members can be attached on a separate sheet of paper.***

I certify that all information provided on this application is true and complete to the best of my knowledge. I understand that willful falsification and/or omission of information may result in denial of financial assistance. I understand that all information is confidential and used solely for enrollment in the Reduced Fee Program.

_____ _____

Applicant/Guarantor's Signature **Date** (mm/dd/yyyy)

Need Help? We're Here for You!
For assistance with your application, call **Family First Health Billing** at **717-845-8617 (Option 3).**
For local office contact information, visit **https://www.familyfirsthealth.org/locations**

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PLEASE DO NOT WRITE BELOW THIS LINE

FOR OFFICE USE ONLY

Family Size: _____ **Gross Household Income Amt: $**_____ **Slide Level:** _____

Primary HH Member Acct#: _____

Effective Date: _____ **Expiration Date:** _____

Processed by: _____ **Approved Date:** _____

IMPORTANT INFORMATION ABOUT SLIDING FEE DISCOUNTS

- **This program helps reduce your out-of-pocket costs** for medical, dental, optometry, behavioral health, podiatry, and prescription services.
- **Everyone is encouraged to apply — even if you have health insurance.**
- If approved, your discount begins the **day we receive your completed application and income documents**.
- Discounts can help with **deductibles, copays, and coinsurance**. If your insurance ends, you will pay only the flat fee for your discount level.
- **New patients may receive a one-time temporary discount** based on verbal income —Self-Declare. Future visits will use your approved discount level.
- **If you have no income**, you must complete a 'Statement of Zero Income' form. Discounts expire after six (6) months. You will receive a reminder to reapply.
- **If you receive Unemployment benefits**, approved discounts will remain active for six (6) months. You will receive a reminder to reapply.
- **If you have income,** approved discounts will remain active for one (1) year. You will receive a reminder to reapply.
- A **household** includes everyone living together at the same address who share income and expenses. Adult children who are financially independent, unrelated roommates, and individuals temporarily staying with friends or relatives are not considered part of your household.
- If you choose **not to apply**, we must still ask your household income for federal reporting. This information is used only for statistics — **your personal details are never shared**. As a FQHC— Federally Qualified Health Centers are required to report income statistics for compliance, to secure and maintain federal funding.

Income Documents REQUIRED if Applicable

Please provide **one** of the following documents for **each Household member** covering the **last 30 days:**

- Pay stubs **or** Employment letter listing gross wages before taxes.
- Unemployment Compensation Determination Letter
- Checks **or** Award letters: SSI, SSD, Alimony, Child Support, Worker's Compensation, and Unemployment
- Pages 1-2 of most recent tax return (Form 1040 or 1040 EZ) **or** most recent W-2
- Documentation of any other sources of income not listed above