Health Care for the Homeless
Discounted/Sliding Fee Application

Patient Name: ______________________________ **Date of Services:** ____________________

It is the policy of Health Care for the Homeless to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but will not cover those services which are purchased from outside. For example, laboratory testing not offered at our clinic, medications, and x-ray interpretation by a consulting radiologist.

In the hope that your financial situation improves, discounts apply only for a period of 6 months. This form must be completed every 6 months for review. Please inquire at the front desk if you have questions.

Number of related persons living in your household: __________

Total household income: (complete one column)

Household Member	Household Income (complete one column)		
	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependent Children Under age 18			
Total			

Note: Include all income all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment, and public aid.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

_________________________________ _________________________________

Name (Print) Signature/Date

Office Use Only

Discount Level: (please circle) A - B – C - D - E – F

Amount Owed $____________ Amount Paid $ _________ Payment Type: __________

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Staff Member's Signature/Date

Revised 08/07/2015