YourTown Health

SLIDING FEE PROGRAM APPLICATION Rev 2018a

Name _____ Date _____

Mailing Address _____

Home Phone _____Cell Phone _____ Email _____

Have you previously enrolled in the Sliding Fee Program? YES NO

HOUSEHOLD INFORMATION

Please list ALL MEMBERS of your household (include yourself). Include those who contribute to the household income and all persons for whom you are financially responsible or those you can claim on your taxes. If the child is over 18, indicate if student.

NAME	BIRTH DATE	RELATIONSHIP
		Self

____ I do not have health insurance coverage

____ I have health insurance coverage through _____

If you have insurance, we will bill your insurance carrier and apply the discount to any balance due for the co-pays and deductibles.

Please fill out the income information section below for all MEMBERS OF YOUR FAMILY. If you have no source of income, please go to zero income section on the next page.

INCOME INFORMATION

Source of Income	Name of Source	Gross Annual Income
Wages		
Self-employed (gross receipts)**		
Social Security Benefits (SSI, Survivor's, Disability)		
Public Assistance (TANF, General Assistance, etc.)		
Child Support/Alimony		
Unemployment Benefits, Worker's Compensation		
Stocks, Dividends, Rental Property		
Interest Income		
Other (Pensions, Veteran's Benefits, Union, etc.)		

****If you are self-employed, you must provide your most recent Federal Income Tax Return (1040) along with Section C.**

YOU MUST INCLUDE PROOF OF INCOME SUCH AS PAYCHECK STUBS, COPIES OF UNEMPLOYMENT CHECKS AND/OR SOCIAL SECURITY CHECKS.

Without proof of income your application will not be processed and your enrollment into the program will be delayed. If you have difficulty getting proof of income, speak to the medical center's Customer Service Representative who can assist in recommending sources of proof. If there are special issues you feel should be considered when we review your application, please include on a separate sheet of paper.

ZERO INCOME

PLEASE FILL OUT ONLY IF YOU HAVE NO SOURCE OF INCOME

Name of last employer _____ Date of last employment _____

Please explain how your basic needs have been met:

Food _____ Utilities _____

Shelter _____ Non-Food Items (clothing, etc.) _____

I, _____ certify that I have had no source of income since _____

All Applicants: PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW

* I agree to be responsible for the YourTown Health bills.
* I also agree to tell YourTown Health if I become eligible for any other form of coverage.
* I understand that if I provide false or incomplete information, I may no longer qualify for a fee discount.
* I certify that the above information on this application is correct and all sources of income required have been reported. I further understand that I will need to update my application annually even if no changes occur.

Signature _____ Date _____

<u>YourTown Health use only</u>: Please select documents received. POI ☐ POA ☐ ID ☐

Grace Period ☐ Date:_____ Scale:_____ CSR Initials:_____

Total no. of family members _____ Payment Eligibility _____

Combined Family Income _____ Date of Application _____

Verification Source _____ Renewal Date _____

Application completed by _____