MRN# _____

Health Care District
OF PALM BEACH COUNTY

## Sliding Fee Scale Eligibility Form

This application is needed to apply for a discount. This information will be kept on file with strict confidence. Your gross annual/yearly household income (before taxes or deductions) and family size, based on the Federal Poverty Guidelines, will be used to calculate a nominal or discount fee. If approved, eligibility will expire in 12 months, and you will need to reapply each year. This application and income document must be submitted within 14 consecutive days of the first clinical visit or within 14 days after an existing sliding fee scale expires.

### Patient Information/Applicant: Parent or legal representative must complete for a minor child.

**First Name:** _____ **Last Name:** _____ **Date of Birth:** ____/____/_____

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

**Email:** _____ **Phone:** (_____)_____ **Cell:** (_____)_____

### Household Information and Income

**What is your marital status?** ☐ Single ☐ Married ☐ Widow(er) ☐ Separated ☐ Divorced

**Housing Status:** ☐ Own ☐ Rent ☐ Live with Someone ☐ Experiencing Homelessness ☐ Temporary Housing

**Do you have insurance (medical/auto/workers' compensation) that will cover all or part of your medical expenses?** ☐ Yes ☐ No

**If yes, provide your insurance card and list: Name of Insurance:** _____ **Member ID:** _____

**Number of people living in your household?** _____ **Is anyone in your household currently pregnant?** ☐ Yes ☐ No

**If yes, how many unborn children?** _____ **Total Family Household Size*:** _____ **(# living in household + unborn = total household size)**

***List each family household member, including YOURSELF, below – include related family members, cohabiting partners, or individuals who share income and expenses, and may include an unborn child if the pregnant individual is part of the household and pregnancy is confirmed by documentation. The unborn will not be listed below.**

| Full Name | Date of Birth | Social Security Number | Employed | Earned Income Schedule |
|---|---|---|---|---|
| Yourself: | | | ☐ Yes ☐ No | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Seasonal ____ |
| | | | ☐ Yes ☐ No | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Seasonal ____ |
| | | | ☐ Yes ☐ No | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Seasonal ____ |
| | | | ☐ Yes ☐ No | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Seasonal ____ |
| | | | ☐ Yes ☐ No | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Seasonal ____ |
| | | | ☐ Yes ☐ No | ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Seasonal ____ |

### List your monthly family household income for monies earned for each family member:

| You | Your Spouse | Your Children (combined) | Other Family Household Members (combined) | Total Household Income |
|---|---|---|---|---|
| $_____ | $_____ | $_____ | $_____ | $_____ |

| Source of Income: Complete the section below that applies to earned income for each employed family member. Noncash benefits such as food stamps and housing subsidies are not counted. | You | Spouse | Children | Other | Total |
|---|---|---|---|---|---|
| Salaries/Wages/Gratuities/Cash Support/Cash Assistance | | | | | |
| Self-Employment Income | | | | | |
| Child Support / Alimony | | | | | |
| Social Security Benefits / Supplemental Security Benefits | | | | | |
| Public Assistance / Disability Benefits | | | | | |
| Retirement Income: Pension/Dividends/Annuities/Earned Interest | | | | | |
| Rental Income / Royalties / Trust Estate | | | | | |
| Workers' Compensation/Unemployment/ Veterans Benefits | | | | | |
| Other (Specify):_____ | | | | | |

**Please provide income documents with your application. Acceptable documents are: Pay Stubs (last four weeks), Social Security and/or Disability Award Letter, Tax Return Form 1040 (for the most current year filing), W2, Unemployment Benefits Letter, Retirement Income Statements, Child Support or Alimony Agreements, and Employer Verification Letter, Self Employment: 1099, Banking Account Statements, Profit and Loss Statement, Tax Return – Schedule C. For questions or assistance regarding income documentation, please see a Financial Assistance Advocate.**

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**Review each section below and only complete the section(s) based on your personal situation.**

**Complete this section only if you have no other way to document your income: Please fill out only the boxes and questions that apply to your personal household situation. This section is designed for individuals who cannot provide standard income documentation. If you have pay stubs or other forms of income proof, DO NOT COMPLETE THIS SECTION.**

## Self-Attestation of Income:

Estimated Monthly Income: $ _____ Household Size: _____

☐ I get paid in cash (I do not get paychecks/pay stubs).
☐ I cannot get a letter from my employer. Explain why:_____
☐ I do not have access to my financial information. Explain why: _____
_____

**Or:**

☐ I currently have **no income**. Provide an explanation below of how basic needs are being met (e.g., shelter, food, transportation):
**Explain**:_____

**Self-Attestation of Homelessness: Complete this section only if you are experiencing homelessness, check the box that applies, and describe.**

**I am currently experiencing homelessness and do not have a fixed, regular, or adequate night-time residence.**

☐ Living on the street (car, park, abandoned building).
Describe location:_____

☐ Temporarily staying with others due to loss of housing.
Describe location:_____

☐ Living in a public or private shelter with temporary housing.
Name of Facility: _____

☐ Fleeing domestic violence and without stable housing.

**I have been without regular housing for:**

☐ Less than 1 month ☐ 1-3 Months ☐ 4-6 months ☐ 7-12 months ☐ More than 1 year

**Sliding Fee Scale Application Consent – Must be completed to apply for the sliding fee scale.**

☐ I understand that the information I provide on this application, including income and household size, will be kept confidential and used solely to determine my eligibility for discounted health care services under the Sliding Fee Discount Program.

☐ I certify that all of the information I have provided in this application, including income and household size is true, correct and complete to the best of my knowledge. I understand that this information will be validated and will be used to determine my eligibility for discounted services.

☐ I agree to notify the Health Care District community health center of any changes to my income, household size, or housing status that may affect my eligibility.

☐ I understand that I must reapply for the sliding fee scale each year, or if my family's size or income changes.

☐ I consent to the use of this information for these purposes and understand that providing false or misleading information may result in a loss of the sliding fee scale discount eligibility.

**Patient Name (Printed):** _____
**Patient/Patient Legal Representative Signature:** _____ **Date:** _____

**Decline Sliding Fee Scale: Complete this section if you do not want to apply for the sliding fee scale.**

☐ I do not want to apply for the Sliding Fee Scale that was offered to me. I understand that I will have to pay for all the services and any medicines I get at the Health Care District community health center. I also understand that I can apply for the Sliding Fee Scale later if I change my mind.

**Patient Name (Printed):** _____

**Patient/Patient Legal Representative Signature:** _____**Date:**_____