CHRIST COMMUNITY HEALTH

Acct#_____

Application for Fee Discounts

Patient Name: _____ Date of Birth: _____

Check if Declining Discounts:

☐ *I Decline all Sliding Fee Discounts. I have received information about available discounts and understand that I can apply anytime in the future.*

List individuals who are usually, primarily, and collectively dependent upon the same Household/Family Income. All individuals included in the calculation of Household/Family Size must live together most of the time. No individual may be considered a member of more than one Household/Family.

Name and Date of Birth	Relation	Income	Week/Month/Year	Christ Community Patient? (circle)
	self			Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

(Continue on separate sheet if necessary)

Provide verification of income for each household member as available. If income verification is not available, please complete Self-Attestation form.

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Examples of income below and acceptable proof of income (only one document needed for each income source):

- Salaries & wages (pay stub, cash app, tax form, letter from employer, Self-Attestation form, etc.)
- Self-employment income (tax form, Self-Attestation form, etc.)
- Retirement, including pensions and social security (Benefit Statement, deposit receipt, etc.)
- Unemployment income (Benefit statement, pay stub)
- Workers' compensation, disability, or other related income (benefit statement, pay stub)
- Child support and alimony received (receipt, benefit statement, bank statement, court document.

If applying for discounts, I understand that by signing below I attest that this information represents my household size and income to the best of my ability. I also understand that these discounts apply only to services rendered while I have an active Sliding Fee Discount. If documentation is returned after a visit within two weeks for a new patient, two weeks of a new application, or two weeks from a renewed application, discounts will be applied up to that two-week period. Also, I understand that all applicable payments are expected at the time of service. New applicants and renewing patients (once a year) may only be required to pay a nominal fee at time of service if application for discounts is pending.

Printed Name_____

Signature: _____

Date: _____

Office Use Only: Approved/Not Approved

Pt Access Rep Signature: _____

Printed Name: _____

ACTIVE SLIDING FEE LEVEL DATE RANGE _____

LEVEL: A B C D E