CHRIST COMMUNITY HEALTH

Application for Fee Discounts

Acct#:_____

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
				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 the **Self-Attestation form**.

Last Revised 5/26/2026

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/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.

Proof of Income MUST be returned within 14 days. If not received after 30 days, your application will be rescinded, and you will decline the SFD by default.

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

Last Revised 5/26/2026