

Application received at:

(Clinic)

2018 Sliding Fee Discount

APPLICATION



Last Name	First name	Primary Phone	Date of Service
-----------	------------	---------------	-----------------

Mailing Address	City	State	Zip
-----------------	------	-------	-----

Household Information	Insurance Status	Ethnicity	Race (please check one)
-----------------------	------------------	-----------	-------------------------

Last Name	First Name	Relationship to applicant	DOB	Insurance Status				Ethnicity Hispanic/Latino? (Yes/No)	Race (please check one)						
				None	Medicaid	Medicare	Private		AK Native / Amer. Indian	White	Asian	Black/ African Amer.	Other Pacific Islander	More than one race	
1															
2															
3															
4															
5															
6															
7															
8															

Please circle your household size and the income for that household size in the column(s) below.

Household size	Monthly Income						Check if income is Greater than Level 4: _____	
	Homeless: Level 0 (\$0 Co-Pay)	Level 1: \$25 Co-Pay	Level 2: \$50 Co-Pay Medical and BH Dental 75%	Level 3: \$75 Co-Pay Medical and BH Dental 50%	Level 4: \$100 Co-Pay Medical and BH Dental 25%			
1	Up to	\$1,265	Up to	\$1,898	Up to	\$2,214	Up to	\$2,530
2		\$1,715		\$2,573		\$3,001		\$3,430
3		\$2,165		\$3,248		\$3,789		\$4,330
4		\$2,615		\$3,923		\$4,576		\$5,230
5		\$3,065		\$4,598		\$5,364		\$6,130
6		\$3,515		\$5,273		\$6,151		\$7,030
7		\$3,965		\$5,948		\$6,939		\$7,930
8		\$4,415		\$6,623		\$7,726		\$8,830
Each Additional member add: \$491			\$736		\$858		\$981	

Household is defined as all members of a family, related or unrelated, who are living together & pooling financial resources, if the arrangements are considered permanent & support greater than room and board is provided.

Return Application to clinic by (date):

Entered in: Cerner

Entered in: MapsIQ

Letter/card sent to patient

Card scanned into EHR