



El Dorado Community Health Center

Sliding Fee Application

A. Client/Patients Information:

Last Name:	First Name:	Initial	D.O.B

B. Household Size:.....Include All members in your family.

Full Name	X*	Gender	Birth Date	Relationship to Client	Marital Status

(* X indicated if the household member is sliding fee eligible)

C. Client/ Household income (indicate the verification method used)

- Paychecks or pay stubs (enough to represent a month's income; ie: 4 weekly or 2 bi-weekly)
- Unearned income (veterans/military benefits, Social Security, SSI, Child Support, Food Stamps, ect.)
- Letter of Income verification from employer (should be on employer letterhead and signed)
- Income Tax Return (use Total Income line or other tax forms (W-2) for most recent year)
- 1-2 months Bank Statements, Other Indicate (Odd Job List)
- NO PROOF OF INCOME PROVIDED (MUST RECEIVE POI WITHIN 5 DAYS)** If no Proof of Income is received within 5 days account will be considered Cash Pay and will be ineligible for Sliding Fee Program.

D. Indicate Income and Calculate Annual Income

Weekly	Bi-Weekly	Twice a month	Monthly	Annual
--------	-----------	---------------	---------	--------

I certify that the above is correct and I currently have no insurance. I also understand that this eligibility for sliding scale services is only for 6 months and expires on: _____ (date)

Signature: _____ Date: _____

For Internal Use Only

Annual Sliding Fee Scale Eligibility Determination

Household Size	
Income	\$
Percent of Federal Poverty Level	%
Client's Sliding Fee Scale Responsibility (Percent or Co-Pay)	% or \$
Eligibility Date	
Expiration Date	
EDCHC Notes:	

Determination made by: _____

Date: _____

