AllCare HEALTH CENTER

Sliding Fee Discount Application

All Care Health Center will provide services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. The discount will apply to all services received at any of our clinics, but not services or equipment that are provided by outside entities.

Patient Name (Last, First, Middle):_____ Date of Birth: _____

Mailing Address (City, State, Zip) _____

Phone Number: _____ Email: _____

Household Size: List all family members living in the household that you are financially responsible for:		
Name	**Relationship**	**Date of Birth**

Household Income: Applicants must provide one (1) of the following for all family members in the household		
Income Documentation	**Monthly Self**	**Benefit Other**
Paycheck Stubs:	$	$
Biweekly: 2 most recent pay stubs	$	$
Weekly: 4 most recent pay stubs	$	$
Monthly: 2 most recent pay stubs	$	$
Social Security Benefits	$	$
Retirement/Pension Benefits	$	$
Disability Benefits	$	$
Unemployment	$	$
Workers Compensation Benefits	$	$
Veteran's Benefits/Military Allotment	$	$
Child Support/Alimony	$	$
Other:	$	$

You have 30 days from the date of your most recent appointment to provide proof of income.

I certify that the family size and income information shown above is correct to the best of my knowledge. By signing this form, you are authorizing All Care Health Center to confirm the information disclosed. The provision of false information may result in dismissal of the sliding fee discount program.

Signature of Applicant:_____ Date: _____

Signature of Intake Representative:_____ Date:_____

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Sliding Fee Discount – Self Declaration

All Care Health Center will provide services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. The discount will apply to all services received at any of our clinics, but not services or equipment that are provided by outside entities.

Patient Name (Last, First, Middle):_____ Date of Birth: _____

Mailing Address (City, State, Zip) _____

Phone Number: _____ Email: _____

Household Size and Income

I declare that my household income is _____per _____.
($) (period)

I also certify that a total of _____people are living in my household.
(number)

By signing below, I attest that:

- I have provided an accurate estimate of household size and income to the best of my knowledge.
- I understand that any approval of a Sliding Fee Discount Application using this self-declaration will only be valid for 30 days, and I will be unable to reapply using a self-declaration.
- I understand that if I do not complete a Sliding Fee Application and provide proof of income prior to my next office visit, that I will be responsible for the full fees of the visit.
- I understand that the provision of false information may result in dismissal from the sliding fee discount program.

Signature of Applicant:_____ Date: _____

Signature of Intake Representative:_____ Date:_____

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Sliding Fee Scale – Proof of Income Documents

You have 30 days from the application date to provide the proof of income

Documents accepted as proof of income (POI):

Choose 1 from the options below

- □ **Employment wages**
  - 2 most recent if paid **biweekly** (30 days of consecutive paystubs)
  - 4 most recent if paid ***weekly*** (30 days of consecutive paystubs)
  - 2 most recent if paid ***monthly*** (60 days of consecutive paystubs)

- □ **Social Security wages** (Social Security Administration Monthly benefit letter dated with most recent calendar year, 1099 forms are *not* accepted)

- □ **Social Security Disability** (Social Security Administration Monthly benefit letter dated with most recent calendar year, 1099 forms are *not* accepted)

- □ **Prior year tax return** (This is good until April 15 of current year, W2s are *not* accepted)

- □ **Current year tax return** (W2s are *not* accepted)

- □ **Proof of income from the Social Security office** (Social Security Earnings Record)

- □ **Unemployment** (Unemployment Benefit Statement must be dated within the last 3 months)

If you do not have any of these documents, please contact an Enrollment Specialist at 712-256-6589 to discuss other documents determined on an individual basis and at the discretion of management. Proof of income can returned to the clinic or be emailed to: enrollment@allcarehealthcenter.org

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