



# APPLICATION FOR FEE DISCOUNT

For your assistance, we have a sliding fee discount program. In order for us to determine if you qualify, please provide us with the following information.

Parent/Guarantor Name: (1) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ NxGn Acct #: \_\_\_\_\_

Patient Name: (2) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How many people are supported by this income?

Use the number of persons who live in the same household and who share income, food and rent. That number may include you, your spouse, and/or any dependents. List additional members on separate sheet if more than eight.

**Other family members:**

Name	Date of Birth	Name	Date of Birth
(3) _____	_____	(6) _____	_____
(4) _____	_____	(7) _____	_____
(5) _____	_____	(8) _____	_____

Indicate all source(s) of income for your household. Please  check all that apply.

Wages and Salary	<input type="checkbox"/>	Support from Family Member	<input type="checkbox"/>
Unemployment	<input type="checkbox"/>	Disability	<input type="checkbox"/>
Self-employment	<input type="checkbox"/>	Pension Funds	<input type="checkbox"/>
Social Security/ SSI	<input type="checkbox"/>	VA Benefits	<input type="checkbox"/>
Child Support	<input type="checkbox"/>	Alimony	<input type="checkbox"/>
Public Assistance/Food stamps	<input type="checkbox"/>	Training Stipends	<input type="checkbox"/>
Workers' Compensation	<input type="checkbox"/>	Scholarships/Grants	<input type="checkbox"/>
Allowance/Gifts	<input type="checkbox"/>	Property rentals	<input type="checkbox"/>
Interest/Dividends	<input type="checkbox"/>	Other (please specify): _____	<input type="checkbox"/>

TOTAL ANNUAL GROSS INCOME \$

(Gross income is before taxes and deductions – line 34/35 on IRS form)

To the best of my knowledge, the information given is true and correct. I give Community Health Center of Snohomish County permission to verify information about my financial status. I understand this information must be provided within 30 days of the date of visit to qualify for sliding fee discount. If this information is not received, then I understand that I will be responsible for the full fee for the visit.

\_\_\_\_\_  
Parent/Guarantor Signature Today's Date

\* \* \* \* \* **For office use only** \* \* \* \* \* **For office use only** \* \* \* \* \*

Verified annual income: \$\$ \_\_\_\_\_ # in household: \_\_\_\_\_ Sliding Scale: \_\_\_\_\_

Proof of income:  IRS  Wage  Other (specify): \_\_\_\_\_

Re-certification Date: \_\_\_\_\_ CHC staff signature: \_\_\_\_\_

BWY  EVG  COL  LYM  LYD  Pharmacy  Admin

**Instructions:** All fields must be completed. Attach Sliding Fee Discount Application, copy of Proof of Income (minimum one full month), and calculation work sheet to today's fee slip, submit to billing with charge batch. If patient wishes discount to be applied retroactively, make a note to the billing staff accordingly.

**Self-Declared No Income**

How are you receiving food and shelter? \_\_\_\_\_  
I attest that my household has no income.

\_\_\_\_\_  
Applicant's Signature Date