Howard Brown Health

Sliding Fee Application

It is the policy of Howard Brown Health Center (HBHC) to provide quality medical care and behavioral health services to all persons in need of care, regardless of income and/or the inability to pay. Please complete the following information so that HBHC will be able to determine your eligibility for discounted services. You will be reassessed for the sliding scale every six months and you will be required to provide updated proof of income.

Legal Name: ***As listed on State ID***

First & Last Name: _____**Preferred Name**: _____

Date of Birth: _____ **Last four digits of Social Security Number**: _____

Do you have commercial health insurance, Medicare, and or Medicaid; County Care or any that pays medical services?

☐ Yes ☐ No ☐ Not Sure

HOUSEHOLD

A "household" includes legal children, a civil union partner or married spouse, and legal dependents. Please list the name of individuals in your household and relation to you. Please use the back of this form for additional space.

Names of individual living in household (including yourself)	Relation to you
TOTAL number of people in household:	

ANNUAL HOUSEHOLD INCOME

Source of Income	Self	Partner	Other	Total
Gross wages, salaries, tips, etc				
Social Security (SSI or SSDI)				
Unemployment Benefits				
Investment Income				
Other				
TOTAL INCOME				

PLEASE READ AND SIGN

I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charged the **full fee of my visit** if I do not bring in documentation of income by my **third visit or within 60 days of my first visit**, whichever comes first. I understand that I am required to notify Howard Brown Health Center if my income level changes or if I become insured. If there are changes, I will be re-assessed for the sliding fee scale.

Print Name: _____

Patient Signature: _____ Date: _____

Guardian Signature (if applicable) :_____

FOR INTERNAL USE ONLY

☐ $0 - RW L1 0-100%

☐ $5 - Non-RW 0-100%

☐ $10: 101-125%

☐ $15: 126-150%

☐ $25: 151-175%

☐ $25: 176-200%

☐ Full Fee (not eligible) greater than 200%

Reviewed By	
Effective Date	
Termination Date	

Revised: 02/01/2017