Sliding Fee Application

Effective 10/10/2024

It is the policy of Howard Brown Health (HBH) 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 HBH 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.

Patient's Name: _____**Preferred Name**: _____

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

Do you have commercial health insurance, Medicare, and/or Medicaid?

☐ Yes ☐ No ☐ Not Sure

HOUSEHOLD

A "household" includes anyone that is found to be the applicant's (you) legal **dependent**, including **children in your legal custody**, a civil union **partner** or married **spouse**. Please list the name of individuals in your household that you are financially responsible for.

Names of dependent	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 in order to be considered for Howard Brown Health's sliding scale program, I must make an appointment with the Benefit Navigation team to discuss insurance coverage options and possible enrollment for programs that are provided by the Illinois Department of Public Health. 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 within 60 days of applying for Howard Brown Health's Sliding Scale program. 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. I understand that this program is only active for 6 months and I will have to reapply at the end of the 6-month period.

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%
☐ $20 - 151-175%
☐ $25 – 176-200%
☐ Full Fee (not eligible) greater than 200%

Reviewed By	
Effective Date	
Termination Date	