

Annual Household Income:

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social Security, pension, annuity, or veterans' benefits				
Alimony, child support, military family allotments				
Income from self-employment and dependents				
Rent, interest, dividends and other income				
Income from Disability and/or unemployment insurance				
Totals				

Please provide proof of income for all household members. Below are acceptable forms of proof:

- Paystubs for most recent full month
- Income tax return
- Pension statement
- Social Services letter
- Employer Statement

I give permission to Jericho Road Community Health Center (JRCHC) to assess if I and/or my family qualify for the sliding fee discount program. I understand that information about my family income and size will be required. I also understand that if the information which I give is false, I will be expected to pay for all services at full charge.

By signing this application, I agree that the information given is true and correct to the best of my knowledge. I understand that it is my responsibility to tell JRCHC of any and all changes in my financial and insurance information.

Print applicant name *Signature of applicant* *Date*

Attestation Statement

I understand that for Jericho Community Health Center to determine eligibility for myself and/or my family to qualify for the sliding scale discount program, I must provide proof of income for each family/household member.

At the time of this application, I am unable to provide proof of income (income verification) for the following family/household member(s):

Name	Relation	Reason

By signing this attestation statement, I understand that I have *14 days* from the date of this application to provide the required proof of income to JRCHC, and that my failure to do so may affect my eligibility and approval for the SDFS program.

Print applicant name *Signature of applicant* *Date*

For services provided by another organization via a formal contract or other written arrangement, JRCHC will ensure that the service provider offers a sliding fee discount program consistent with this policy (i.e. fees will be discounted for patients with income between 100% and 200% of the FPG, patients with income below 100% FPG will receive a full discount or assessed a nominal charge only, and patients with income above 200% FPG will receive no discount).

For Office Use Only	
Applicant Eligible For:	<input type="checkbox"/> Medicaid <input type="checkbox"/> ACA <input type="checkbox"/> Sliding Fee Scale Discount – Qualifies for Category _____ discount <input type="checkbox"/> Full Pay
Further Action Required: <input type="checkbox"/> Two week review: collect further documentation <input type="checkbox"/> Other: _____	
Application Reviewed by:	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved by:
Employee Signature:	Date:
<input type="checkbox"/> Six month review: Date: _____ <input type="checkbox"/> Eligibility continued _____	
Employee Signature:	Date: _____

VERIFICATION LIST	YES	NO
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		