SLIDING FEE DISCOUNT PROGRAM APPLICATION

This program helps reduce the cost of care for patients based on income and household size.

Patient Information

Patient Name: _____ **Date of Birth:** ____ / ____ / _____
Last, First Middle

Date of Request: ____ / ____ / _____ **Date of Appointment:** ____ / ____ / _____

Contact Information

Current Address:
Street _____

City _____ State _____ Zip _____

☐ I do not have a reliable mailing address right now
☐ This is a shelter, day center, or temporary housing

If using a shelter, day center, or organization address:
Organization Name: _____
Contact Person (if known): _____

Where are you staying today? (Optional)
☐ Unsheltered / homeless
☐ Shelter or transitional housing
☐ Staying with friends or family
☐ Own or rent home
☐ Other: _____

Phone:
Cell _____ Alternate _____
☐ I do not have a working phone right now

Household Information

Please count yourself and anyone who lives with you and shares expenses. A household is defined to include related individuals by birth, marriage or adoption as well as same-sex couples, and common law households. Roommates, unrelated individuals who share rent and utility bills in exchange for a share of space in a living unit, are not considered part of the household for determination.

Please select one:
☐ Household of one (just me)
☐ More than one person in household — total number of people **including yourself**: _____

Please list household members:

	Name	**Date of Birth**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

Household Income

Please list income for all adult household members (as defined above). If you do not have income, write "0." If income changes month-to-month, estimate your average.

Source	**Annual Amount**
Gross wages, salaries, tips	$_____
Social Security	$_____
Disability	$_____
Farm/Self-employment (net)	$_____
Unemployment	$_____
Public assistance (not food stamps)	$_____
Workers' compensation	$_____
Alimony	$_____
Child support	$_____
Military income	$_____
VA benefits	$_____
Pensions/annuities	$_____
Interest/dividends	$_____
Rental income	$_____

Total Household Income: $_____

Proof of Income

We ask for proof of income. If you do not have documents, please let us know. A staff member can help document your situation.

Please select one:
☐ I have income documents which are attached to this application, including income documents for all household members identified.
☐ I have no current income and request assistance from a relevant staff member to complete a Zero Income Declaration.

Examples of proof of income include:
- W-2 Form or most current pay stubs for last month of employment
- Current tax return
- Unemployment, Social Security, Disability, Workers' Compensation award letter
- Child support and / or alimony award letter
- Pension or retirement income information
- Letter from employer establishing income
- Letter from person/persons supplying support showing amount and frequency of support
- Letter from a nonprofit or shelter

Insurance Information (if applicable)

The Wright Center for Community Health does not require patients to enroll in public or private insurance. However, staff are available to help educate patients about publicly funded health care coverage, such as Medicaid, for which they may qualify. In many cases, we can also assist eligible patients with the enrollment process for certain benefits and coverage. Please let a staff member know if you are interested.

Medical Insurance: ☐ Yes ☐ No
If yes:

Insurance Carrier (Name and Address): _____
Policy #: _____
Policy Holder: _____ DOB of Policy Holder: _____

Dental Insurance: ☐ Yes ☐ No
If yes:

Insurance Carrier (Name and Address): _____
Policy #: _____
Policy Holder: _____ DOB of Policy Holder: _____

Employment (if applicable)

Occupation: _____

Employer Name: _____

Employer Address: _____

City _____ State _____ Zip _____

If your financial situation has changed since your last application, please provide proof of your current income or financial status and include a brief explanation describing the change.

Patient Statement

I confirm that the information I provided is true and accurate to the best of my knowledge. Please check all.

By signing this form, I understand and agree that:

- ☐ I understand that additional documentation may be required to determine eligibility for the Sliding Fee Discount Program (SFDP).
- ☐ I understand that The Wright Center for Community Health may assign a Community Health Worker or Case Manager to support me and/or my family.
- ☐ I agree to notify The Wright Center for Community Health of any changes in my financial situation, household size, or household income, including changes to income that fall below 200% of the Federal Poverty Level.
- ☐ If I use an address that is not my own, I have permission to use it and can receive mail there.
- ☐ I declare under penalty of perjury that the information provided is true and accurate.

Signature of Patient or Guardian _____ Date ____ / ____ / _____

Relationship to Patient (if applicable) _____

END OF APPLICATION – STOP HERE - UNLESS COMPLETING A ZERO INCOME AFFIDAVIT

ZERO INCOME DECLARATION

Patient Information

Patient Name: _____ **Date of Birth:** ____ / ____ / _____
Last, First Middle

Date of Declaration: ____ / ____ / _____

This is to document that I, _____, have no income.

Please tell us how you are meeting your needs for the following items. If someone else is assisting you with any of the following, include their full name and amounts paid (if applicable). If you are living in a shelter, using food banks/soup kitchens, etc., please provide the names of those locations.

Food

Housing

☐ Unsheltered / homeless
☐ Shelter or transitional housing
☐ Staying with friends or family
☐ Own or rent home

Utilities

Patient Statement

By signing this form, I understand and agree that:

☐ I declare under penalty of perjury that the information provided is true, accurate and complete.

Signature of Patient or Guardian _____ Date ____ / ____ / _____

Relationship to Patient (if applicable) _____

END OF ZERO INCOME DECLARATION - STOP HERE