St. Croix Regional Family Health Center
Sliding Fee Discount Schedule Program Application

Proof of income ***must accompany*** this application. If you do not have your proof of income, please keep this application and return with the proper forms. Proof of income can include your most recent federal income tax return, paycheck stubs (**4 weeks required**), most recent W-2 Forms, benefit letters or statements that show proof of what you receive for social security, unemployment, workers compensation, child support, etc.

Date: _____

Name: _____ **Date of Birth:** _____ **Telephone:**_____

Physical Address: _____

Employer: _____ **Insurance:** _____

Please list names and birth dates of all family members that live in your household, including applicant:

Name	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that SCRFHC receives federal funding and provides discounts to patients who qualify based on income and family size.
I understand that these discounts are only for patients who meet eligibility criteria established by the Federal Government. I understand that if I qualify for discounted services, they will provide to me as long as I continue to qualify. I agree to inform SCRFHC of any substantial change in my financial status that could prevent me for being eligible for the discount. I also agree to provide updated proof of income at future visits upon request.

I understand that SCRFHC requires a minimum fee of $20.00 at each visit, and I am expected to pay the minimum fee and any other charges when requested. If I am eligible for Medicare part B or private insurance coverage, I may also be eligible for the SCRFHC Sliding Fee Discount Program. However, discount will only be applied after third party payments or assignments.
I understand that I am responsible for all charges billed to me not covered by third party payors, and that SCRFHC may refuse to provide non-emergency medical services and may engage a collection agency to collect form me if I fail to make timely payments. Knowing their limitations, I hereby request discounted medical services SCRFHC.
I attest that all information, including the attached proof of income, is true and accurate.

SCRFHC provides for fees to be reduced or waived under special circumstances. Please request to speak to a Patient Assistance Representative if you meet at least one of the following criteria: Have no income, meet the definition of homelessness, are staying in a shelter or on the street, are seeking political asylum, or are unable to work due to immigration status.

Applicant Signature: _____

OFFICE USE:

Annual adjusted gross income: _____

Based on the above information, the applicant eligible for a sliding fee adjustment of: _____%

Approved By: _____ Date: _____