Mountaineer Community Health Center

This form must be returned within ***30 days*** of your bill to receive discount. ***Incomplete applications will not be processed.***

Sliding Fee Application

Instructions: (Please Print)

Complete this form for sliding fee discounts based on your household income. This form must be returned with proof of income within **30 days** of your bill to receive a sliding fee discount. Help completing this form and our complete sliding fee discount policy is available from our Certified Application Counselors.

Please include these people in your household:

- Yourself
- Your spouse
- Your tax dependents
- Your unmarried partner (if you have a child together)
- Anyone under 19 who you take care of and lives with you
- Anyone that claims you as a dependent

Address: _____ **Phone:** _____
Street

_____
City **State** **Zip**

List Names	Date of Birth	SS#	Relationship	Office use only Account #
1.			PATIENT	
2.				
3.				
4.				
5.				
6.				
7.				

Include income for all people in the household including: • Job income • Social Security • Net self-employment • Alimony • Retirement/pension • Investment/rental **Do not include child support, SSI, workers' comp, or VA

You may subtract certain deductions including: • Alimony Paid • Student loan interest • Pre-tax paycheck deductions

Total Annual Household Income _____ or Total Monthly Household Income _____

By signing this application, I certify that this information is complete to the best of my knowledge. I understand that my copay is due at the time of each visit. I also understand that if I knowingly provide false or incomplete information, any sliding fee discount received will be removed and I will be barred from receiving future discounts.

Patient Signature: _____ Date: _____

Office Use Only

Reviewed by: _____ **Start Date**: _____

Expiration Date: _____

Eligibility Level	**1**	**2**	**3**	**4**	**5**	
Copay/Nom. Fee	$10	$15	$20	$40	No Discount	Notes: _____