MACT HEALTH BOARD, INC.
Sliding Fee Scale
MEDICAL/DENTAL CLINIC

(Please circle one location and either medical or dental)

JACKSON	MARIPOSA	SAN ANDREAS	SONORA

MEDICAL	DENTAL

NON-CHS ELIGIBLE REDUCED FEE DETERMINATION WORKSHEET

For some qualified families, medical/dental services are available at a reduced fee determined by the size of your immediate family and your present income.

Name	Address
Phone	City, State, Zip

Total Number of dependents living in your household (include yourself/spouse, children, and any dependent relatives living with you: _____

Last Name	**First Name**	**Relationship**	**Age**

List additional names on back of this page.

NON-CHS ELIGIBLE REDUCED FEE DETERMINATION WORKSHEET

3. Are you currently employed? ☐ Yes ☐ No

If you are employed, complete the following:

Employer Name	Employer Address
Employer Phone	City, State, Zip

4. Is your spouse currently employed? ☐ Yes ☐ No

If your spouse is employed, complete the following:

Employer Name	Employer Address
Employer Phone	City, State, Zip

5. Please complete your income information:

Your Income	**Amount**
Weekly	
Bi-Weekly	
Twice Monthly	
Monthly	
Spouse's Income	**Amount**
Weekly	
Bi-Weekly	
Twice Monthly	
Monthly	
Other Income	**Amount**
Weekly	
Bi-Weekly	
Twice Monthly	
Monthly	
*Source of other Income:	

6. You are required to provide proof of your, your spouse's, and any other income(s) for the last three months. Acceptable documentation of your income can be any combination of:

Federal/State Income Tax Forms
Unemployment Vouchers
Pay Receipts (stubs)
Bank Statements
Other information you feel is pertinent

7. I certify that the above information is correct and accurate and the best of my knowledge represents all the sources of income for the family listed in this application.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____

Completed Application Received:

Received by: _____ Date: _____

NON-CHS ELIGIBLE REDUCED FEE DETERMINATION WORKSHEET

** MACT HEALTH BOARD RECEPTION USE ONLY **

VERIFICATION AND DETERMINATION

Applicant Name: _____

☐ Monthly income verification attached.

☐ Monthly income computation completed for:

☐ Applicant $_____

☐ Spouse $_____

☐ Other $_____

Total Monthly Income $_____

4. Fee reduction recommendation: ☐ 5% ☐ 10% ☐ 15% ☐ 20%

Verification and determination by: _____

Receptionist

Date: _____