UNICARE COMMUNITY HEALTH CENTER, INC.
SLIDING FEE SCALE APPLICATION

_____ I am not interested in disclosing my financial information, therefore my family and I are not eligible for the sliding fee discount program.

_____ I am interested in disclosing my financial information and being screened for the sliding fee discount program.

PATIENT INFORMATION		Today's Date: / /	
First Name:	Middle:	Last:	Date of Birth:
Phone Number:		Other names:	

FAMILY SIZE (INCLUDING YOURSELF)			
Name	Relationship	Date of Birth	Age (in years)
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

INCOME (PLEASE LIST YOUR GROSS INCOME – WHICH IS INCOME BEFORE TAXES AND DEDUCTIONS.)					
	You	Spouse	Children	Other	
Employment					
Social Security					
Public Assistance					
Retirement Pension					
Child Support, Alimony					
Other					
TOTAL	$	$	$	$	$

INCOME VERIFICATION

☐ Attached is my income documentation– tax records, paystubs, employer letter, etc.

☐ I have no documentation to verify my income: (Please check all that apply.)

- ☐ I get paid in cash.
- ☐ I do not get paychecks or pay stubs.
- ☐ I did not file a tax return last year
- ☐ I cannot get a letter from my employer.

UNICARE COMMUNITY HEALTH CENTER, INC.
SLIDING FEE SCALE APPLICATION

PATIENT INFORMATION			
First Name:	Middle:	Last:	Date of Birth:

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me and my family from further consideration for the sliding fee discount program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Unicare Community Health Center if there is a significant change in my income. If acceptance to the sliding fee discount program is obtained under this application, I will comply with all rules and regulations of the Unicare Community Health Center. I hereby acknowledge that I read and understand the foregoing disclosure.

SIGNATURE DATE

PRINT NAME

* * * * * * * * * * * * * * * *

INTERNAL USE ONLY

Income verification using (Circle One):

Previous Year Tax Return Payroll Check Stubs Proof of Social Security benefits (or other benefits) Self-Attestation Form

Employer Letter Other (Specify): _____

Annual Gross Income Calculations:

Weekly (1 week pay stub or total pymts)
$ _____ *52= $ _____

Biweekly (2 weekly pay stubs or 1 biweekly pay stub or total pymts)
$ _____ *26 = $ _____

Previous Year Tax Return
1040 Line 7 $ _____

Eligible Family Size: _____ Total Gross Household Income: $ _____ Scale: _____

REVIEWED BY: UCHC STAFF (SIGNATURE) DATE

APPROVAL BY: OFFICE MANAGER (PRINT NAME) SIGNATURE