Sliding Fee Scale Application

Patient Information			Today's Date: / /
First Name:	Middle:	Last:	Other names:
Home Phone #: ( ) -		Date of Birth: / /	
Social Security # - -	Do you have insurance? (circle one) Yes No		Name of Insurance Carrier:

Household Size			Family size _____
Name	**Relationship**	**Date of Birth**	**Social Security Number**
		/ /	- -
		/ /	- -
		/ /	- -
		/ /	- -
		/ /	- -

Household Income (Please list your GROSS income)

Name	Amount	Frequency (Circle one)	Employer:
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	You	Spouse	Children	Other	Subtotal
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

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 from further consideration for the sliding fee 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 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: _____

Reviewed by UCHC Staff: _____ Date: _____ Approval: Yes/No Scale: _____