Heritage Health

SLIDING FEE APPLICATION

To Be Completed by Patient/Guardian for EACH member of the household:				
	Name	Relationship	Date of Birth	Annual Income
1				
2				
3				
4				
5				
6				

☐ Please check here if you refuse to provide income information, please note that you will be ineligible for the sliding fee discount if you do not provide this information.

If you have no household income please explain, in detail, how you are supporting yourself/family. **Note:** Your case will be reviewed further to determine if a slide discount is warranted/appropriate. A follow-up form and interview will be required.

_____

_____

_____

_____

_____

Acknowledgment

To the best of my knowledge, the information above is true and correct. I understand if income verification documents are not provided within 30 days, I will be billed the full fee for services. I understand it is my responsibility to notify Heritage Health of any changes to my income. I also understand that I must re-apply for a sliding discount schedule at least once every 12 months, or sooner if my income changes.

Print Name:_____ DOB: _____
(Last) (First) (M.I.)

Signature:_____ Date: _____

Relationship to Patient:_____

DO NOT write below this line. To be completed by Heritage Health.

- ☐ Income documentation in line with "Payment for Services" requirements?
- ☐ All adult family members provided POI?
- ☐ Calculated the annual gross income for the family?
- ☐ Updated patient status in the billing system?
- ☐ Notify billing department for established patients?
- ☐ If no POI, notified patient to bring within 30 days?

Slide Group: _____ Expiration Date: _____ CSR Initials: _____

Heritage Health

Self-Declaration of Income

Patient Name:_____ DOB_____ Date:_____

List Household members below: *(Household is defined as those residing together as a family unit and supported by a common household income)*

Name	Relationship	Receives Income (Y/N)

Please list all combined gross monthly income received (Wages, SS, state assistance, alimony, child support, other)

Wages		Child Support	
Wages		Retirement	
State Assistance		Unemployment	
Alimony		Other:	
Social Security		Other:	
		Total Monthly Income	

Are you currently homeless? No_____ Yes_____
If yes, please describe your current living situation:

_____

_____

If you have no income, please explain how you pay your monthly expenses including housing:

_____

_____

I certify that the information above is accurate and correct, and I understand that falsification of this document could result in full charges. I understand that I am responsible for advising Heritage Health in the event of change in my living status or change in my monthly income.

Signature:_____ Date_____

_____

For official use only:

*Homeless Status: No_____ Yes_____ ; details*_____

*Amount of supported monthly income*_____ *x 12=* _____ *(Annual Income)*

*Number of supported people in a household*_____ *Group #*_____ *CSR initials*_____