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.

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Acknowledgement

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:** _____/_____/_____

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: ________ **CSR Initials:** ___________ **Date Form Expires:** __________

REV. 10/18