One Community Health
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Sliding Fee Discount Application

It is the policy of One Community Health to provide essential services regardless of the patient's inability to pay. Discounts are offered based on family size and annual income. Pleased complete the following information and return it to the Eligibility Department to determine if you or members of your family are eligible for a discount.

The discount will apply to all medically necessary services received at One Community Health, but not those services or equipment that are purchased from outside the health center or that may be considered essential services. This form must be completed annually or if your financial status changes.

NAME			SOCIAL SECURITY #	
STREET	CITY	STATE	ZIP	PHONE
RESPONSIBLE PARTY (for payment):			MARITAL STATUS (single, married, domestic partner)	

Please list spouse/domestic partner and all members of your family.
See page 3 for definition of family. Attach additional pages if needed.

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
Self		Family Member	
Spouse/Domestic Partner		Family Member	
Family Member		Family Member	

Annual Income
See page 3 for definition of income

SOURCE	SELF	SPOUSE/DOMESTIC PARTNER	OTHER	TOTAL
Gross wages, salaries, tips, bonuses, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security Payments, public assistance, veterans' payments, survivor benefits, pension or retirement income.				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.				
TOTAL INCOME				

NOTE: **Copies of tax returns, paystubs, or other information verifying income will be required before a discount is approved.**

I certify that the family size and income information show above is true and correct.

Name (Print) _____

Signature _____ **Date:**_____

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Important Definitions

For the purposes of the Sliding Fee Discount Program (SFDP) Family is defined as: A group of two or more persons related by birth, marriage, domestic partnership, adoption or foster care who live together for at least half of the year (or would be, if not incarcerated, in foster care, residing in a long-term care facility, attending school or deployed by the military). Individuals who are not related and occupy the same housing unit, such as roommates, are not considered family members.

For the purposes of the SFDP income is defined as: Modified adjusted gross income is calculated according to Medi-Cal guidelines. Countable income includes gross salary/wages, tips, capital investments, alimony, unemployment benefits, workers compensation benefits, pensions and passive or active monetary gain. Child support, Supplemental Security Income (SSI) and welfare benefits are not included. Net income of business or self-employment earnings is included.

For the purposes of the SFDP the following are examples of acceptable as proof of income:

- Two (2) most recent pay stubs
- Letter from employer on company letterhead stating hours worked per week and pay per hour
- prior year tax return (including Schedule C, if applicable);
- Social Security Statements
- Court-ordered child support or alimony
- Unemployment check stubs
- Bank Statements
- Self-declaration of income under penalty of perjury, acceptable when no other proof of income is available

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Patient Self-Declaration of Income

PATIENT INFORMATION				
NAME		DOB		
STREET	CITY	STATE	ZIP	PHONE

Declaration of Employment:

I _____ declare that I am presently: [ ] employed [ ] unemployed.

If employed, my employer's name is: _____

Employer's phone number: _____

Employer's address: _____

I declare that my household income last [ ] month or [ ] year was $_____.

I understand that sources of income include, **but are not limited to**, the following: employment by other(s), retirement funds, unemployment compensation, alimony, social security income, assets, workers' compensation, pensions, educational grants/ work-study, disability, self-employment income, union benefits, family support, as well as any other source not listed above.

Patient Statement
I certify, under penalty of perjury that the information contained above is complete and accurate to the best of my knowledge. I understand that I am signing this statement under penalty of prosecution if I knowingly give false information, which results in assistance received for which I am not eligible.

Patient Signature:_____ Date _____

For Minor: If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

Parent/Guardian Signature:_____ Date _____

One Community Health Staff Verification: I understand that third-party verification is the preferred method of verifying eligibility documentation. I understand self-declaration is only permitted when income documentation does not exist or there is no reasonable option for providing the documentation.

One Community Health Staff Name (Print): _____

One Community Health Signature:_____Date_____